

COMDTINST M6000  
27 June 2001

COMMANDANT NOTICE 6000

Subj: CH-16 TO MEDICAL MANUAL, COMDTINST M6000.1B

1. PURPOSE. This Notice publishes revisions to Medical Manual, COMDTINST M6000.1B. Intended user of this directive are all Coast Guard Units that maintain medical Manuals.
2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of Headquarters units, Assistant Commandants for directorates, Chief Counsel and special staff offices at Headquarters shall ensure compliance with the provisions of this Notice.
3. DIRECTIVES AFFECTED. Medical Manual, COMDTINST M6000.1B.
4. SUMMARY. Newly revised material and editorial changes are denoted by a line on the outside of the page. Enclosure (1) summarizes the substantial changes throughout the Manual provided as enclosure (2).
5. PROCEDURES. No paper distribution will be made of this Manual. Official distribution will be via the Coast Guard Directives System CD-ROM and the Department of Transportation Website <http://isdcdc.dot.gov/>. An electronic version will also be made available via the Commandant (G-WK) Publications and Directives website (see # 6, below).

a. Remove and insert the following pages

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Chapter 1 CH-15  
Chapter 2 CH-14  
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NON-STANDARD DISTRIBUTION:



6. FORMS AVAILABILITY. All forms listed in this Manual with the exception noted in this paragraph are available from stock points listed in the Catalog of Forms, COMDTINST 5213.6. The stock number for DD Form 2766 (Rev 01-00), Adult Preventive and Chronic Care Flowsheet, Sponsor (Navy) is 2766-0102-LF-984-8400 (pkg 100). The DD-877, Request for Medical/Dental Records no longer has a stock number. Availability of this form is only by .pdf format, a web link is provided on the Pubs and Directives web page. Some forms referenced in this manual are also available on SWSIII Jet Form Filler. Web links to forms in .pdf format have been provided on the Pubs and Directives page; <http://www.uscg.mil/hq/g-w/g-wk/g-wkh/g-wkh-1/Pubs/Pubs.Direct.htm>.



JOYCE M. JOHNSON  
Director of Health and Safety

- Encl (1) Summary of substantial changes  
(2) CH-16 to Medical Manual, COMDTINST M6000.1B



## CH-16 TO MEDICAL MANUAL, COMDTINST M6000.1B

| <b>Chapter 1</b>                       |   |
|--|---|
| <b>Chapter 1-B-1.a.i:</b>              | Specifies the patient will be notified of all abnormal test results.  |
| <b>Chapter 1</b>                       | Chapter layout re-formatted for uniformity.   |
| <b>Chapter 2</b>                       |   |
| <b>Chapter 2-A-6</b>                   | Provides guidelines for Elective Health Care.   |
| <b>Chapter 2-A-7</b>                   | Provides guideline for Other Health Insurance (OHI).  |
| <b>Chapter 2-F-3.a</b>                 | Provides new guidelines for Members of Foreign Military Services.   |
| <b>Chapter 2-I-1-e:</b>                | Provides definition for Super Sickbay   |
| <b>Chapter 2</b>                       | Chapter layout re-formatted for uniformity.   |
| <b>Chapter 3</b>                       |   |
| <b>Figure 3-A-1</b>                    | Revised Overseas Modified Screening to reflect DNA sample.  |
| <b>Figure 3-B-2</b>                    | Revised to show current routing symbol. Re-added (5) to NOTES.  |
| <b>Chapter 3-B-c.(3)</b>               | Revised text to read: Upon completion of flight training and assignment to a Coast Guard unit, the NOMI approved physical will be considered valid until the last day of the member's next birth month. |
| <b>Chapter 3-C-19</b>                  | Item 18 (Dental) portion of the SF 88, Report of Medical Exam, updated to show current accession standards in 3-D.  |
| <b>Chapter 3, Figure 3-C-2</b>         | Dental Carious Teeth Standards removed from chapter. Reflects current standards in section 3-D.   |
| <b>Chapter 3, Figure 3-C-3</b>         | Reduced height standard for (Candidate for Flight Training) from 64 to 62 inches.   |
| <b>Chapter 3-D</b>                     | Revised Section D to reflect DOD Directive 6130.4 dtd Dec 14,2000, P.E. Standards for Entrance into the Coast Guard.  |
| <b>Chapter 3-F-5-</b>                  | Provides guidelines for Corneal Refractive Surgery.   |
| <b>Chapter 3-F-7-b.(2)</b>             | Provides new definition for Bronchial Asthma.   |
| <b>Chapter 3-F-8-a.(5)</b>             | Provides new definition for Myocarditis and degeneration of the myocardium.   |
| <b>Chapter 3-F-8.b.(9)</b>             | Revised text to read: Any condition requiring anti-thrombotic medication other than aspirin.  |
| <b>Chapter 3-F-10-a.(8) &amp; (13)</b> | Provides new definition for Crohn's Disease and Ulcerative Colitis.   |
| <b>3-F-10.e</b>                        | Provides new definition for Diabetes Mellitus.  |
| <b>3-F-15.e</b>                        | Provides new definition for Convulsive Disorders.   |
| <b>3-F-18.e</b>                        | Provides new definition for Purpura and other bleeding diseases.  |
| <b>3-F-22</b>                          | Revised definition for HIV to read identical to HIV ALCOAST #425/00.  |
| <b>3-G-4.d</b>                         | Provides new height standards for Class 1 Aviators (62) inches.   |
| <b>3-G-6.a.(1).(a)</b>                 | Provides new guidelines for anthropometric measurements for Candidates for Flight Training.   |
| <b>Chapter 3</b>                       | Chapter layout re-formatted for uniformity  |



| <b>Chapter 4</b>               |   |
|--------------------------------|---|
| <b>Chapter 4-A-5.a.(8)</b>     | Provides definition for Custody of Health Records.  |
| <b>Chapter 4-A-6</b>           | Provides new guidance for Transfer of Health Records.   |
| <b>Chapter 4-B-3</b>           | Provides guidance and adds new form DD-2766 (Adult Preventive and Chronic Care Flowsheet) Note: Problem Summary List is now obsolete.   |
| <b>Chapter 4-B-32</b>          | Provides guidance and adds form DD-877 (Request for Medical/Dental Records or Information).   |
| <b>Chapter 4-D-8</b>           | Provides guidelines for the Transfer of Clinic Records.   |
| <b>4-G</b>                     | Provides guidelines for Mental Health Records (a new section).  |
| <b>Chapter 4</b>               | Chapter layout re-formatted for uniformity. Most forms updated to show current form available as a word document..  |
| <b>Chapter 5</b>               |   |
| <b>Chapter 5-C</b>             | Provides new section C. Command directed Mental Health Evaluation of CG Members.  |
| <b>Chapter 5</b>               | Chapter layout re-formatted for uniformity.   |
| <b>Chapter 6</b>               |   |
| <b>Chapter 6-A-6</b>           | Provides new guidance for Inpatient Hospitalization message to include ICD-9 code for diagnosis.  |
| <b>Chapter 6-B-8</b>           | Provides guidelines for the DD-2766 Adult Preventive and Chronic Care Flowsheet.  |
| <b>Removed CG5534</b>          | Removed CG 5534 Non Fed Med as per ALCOAST #129/01, cancellation of COMDTINST 6010.20.  |
| <b>Chapter 6</b>               | Chapter layout re-formatted for uniformity.   |
| <b>Chapter 9</b>               |   |
| <b>Chapter 9-A-4.a.(10)</b>    | Provides guidelines for unit instruction or SOP in the event of family violence.  |
| <b>Chapter 9-A-9.b.(2).(a)</b> | Provides guidelines for signs on interior surfaces of cutters.  |
| <b>9.A.7.h.</b>                | Removes the reference to Chapter 10 of the Coast Guard Rescue and Survival Systems Manual for guidance on inspection and maintenance of the Rescue EMT Set and requirements for documentation of those procedures in a Preventive Maintenance Schedule (PMS) log. |
| <b>9-A-8.b.(2)(f)</b>          | Removes requirement to maintain a Preventive Maintenance Schedule (PMS) log. The requirement for this has been removed from the Coast Guard Rescue and Survival Systems Manual (COMDTINST M10470.10 (series)).  |
| <b>Chapter 9</b>               | Chapter layout re-formatted for uniformity.   |
| <b>Chapter 12</b>              |   |
| <b>Chapter 12-A-2.c</b>        | Provides guidelines for Enrollment Criteria.  |
| <b>Chapter 12-A-3.a.(1)</b>    | Provides guidance for using the most current OMSEP Physical Form (6-00).  |
| <b>Chapter 12-A-3.b</b>        | Provides guidance for the OMSEP database.   |
| <b>Chapter 12-A-5</b>          | Provides new guidance for Roles and Responsibilities.   |
| <b>Chapter 12-A-5.a</b>        | Provides new guidance for OMSEP Coordinators.   |



|                                       |  |
|---------------------------------------|--|
| <b>Chapter 12-A-5.e</b>               | Provides new guidance for Medical Officer's responsibilities.                  |
| <b>Chapter 12-A-5.f</b>               | Provides guidance for Medical Administrators.                                  |
| <b>Chapter 12-A-g</b>                 | Provides guidelines for civilian OMSEP enrollees.                              |
| <b>Chapter 12-B-2.d.(1) &amp; (2)</b> | Provides new section (1) and (2), End of Exposure guidelines.                  |
| <b>Chapter 12-B-2.e</b>               | Provides guidance for time intervals between OMSEP examinations.               |
| <b>Chapter 12 forms</b>               | Table 12-C-1 to 12-C-12 were revised and updated to show current requirements. |
| <b>Chapter 12</b>                     | Chapter layout re-formatted for uniformity.                                    |



# CHAPTER 1

## ORGANIZATION AND PERSONNEL

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## CHAPTER 1. ORGANIZATION AND PERSONNEL

### Section A - Organization.

1. Mission of the Coast Guard Health Services Program.
  - a. The Health Services Program supports Coast Guard missions by providing quality health care to maintain a fit and healthy active duty corps, by meeting the health care needs of dependents and retirees to the maximum extent permitted by law and resources, and by providing authorized occupational health services to civilian employees.
2. Director of Health and Safety.
  - b. Mission. The mission of the Director of Health and Safety is to:
    - (1) serve as advisor to the Secretary of Transportation;
    - (2) serve as advisor to the Commandant; and
    - (3) develop and implement the Coast Guard's overall health care program.
  - c. Duties and Responsibilities. Under the general direction and supervision of the Commandant, Vice Commandant, and the Chief of Staff, the Director of Health and Safety shall assume the following duties and responsibilities:
    - (1) serve as Program Director (PD) for the Health Services Program (G-WKH), and the Safety and Environmental Health Program (G-WKS);
    - (2) act as advisor to the Commandant in providing counsel and advice on:
      - (a) health care issues affecting operational readiness and quality of life in the Coast Guard;
      - (b) interdepartmental and interservice agreements for health care of Coast Guard personnel;
      - (c) the significance of legislative matters affecting the Coast Guard Health Services and Safety and Environmental Health Programs; and
      - (d) important developments in the Department of Defense and the Department of Health and Human Services which affect the Coast Guard Health Services and Safety and Environmental Health Programs;
    - (3) serve as advisor to the Secretary in developing and implementing departmental national defense emergency medical, health, and sanitation policies and plans (except those involving civil aviation) and such other advisory services that may be required or requested;



- (4) plan, develop, and administer a comprehensive, high quality health care program (quality is defined as the desired level of performance against established standards and criteria) for all authorized beneficiaries;
- (5) plan, develop and administer a comprehensive program for the prevention of illness and injury of Coast Guard personnel and dependents, to reduce losses, and protect the environment in Coast Guard working facilities and living spaces/by establishing and maintaining adequate safety and environmental health standards for aircraft, vessel, shore facilities, and motor vehicle; providing information and encouragement to beneficiaries for personal wellness programs and providing healthy and pleasing meals at Coast Guard dining facilities;
- (6) administer TRICARE Management Activity (TMA), including the appropriation of funds, on behalf of the Coast Guard as provided in the Dependents Medical Care Act and regulations pursuant thereto;
- (7) monitor and protect the health of personnel attached to the Coast Guard through the Occupational Medical Surveillance and Evaluation Program (OMSEP);
- (8) direct the administration of funds in those appropriations or allotment fund codes under the control of the Office of Health and Safety, including furnishing total budget estimates and apportionment or allotment recommendations to the Chief of Staff;
- (9) advise responsible offices concerning establishing physical standards for military duty and special operational programs;
- (10) procure and recommend assignments to the Commander, Coast Guard Personnel Command (CGPC), and review the performance of Public Health Service personnel detailed to the Coast Guard;
- (11) provide professional health care guidance to all health services personnel;
- (12) maintain liaison with the Public Health Service, the Department of Veterans Affairs, the Department of Defense, and other Federal agencies and serve on interservice boards and committees as appointed;
- (13) set policy and guidelines for the subsistence program;
- (14) provide technical advice to operating program managers;
- (15) set policy and guidelines for health care quality assurance; and act as the Governing Body for Coast Guard health care;
- (16) set policy and guidelines for the Alcohol Abuse Prevention program; and
- (17) serve as a member of the Human Resources Coordinating Council.
- (18) administer the Coast Guard Emergency Medical system.



- (19) Public Health Service. The responsibility of the Public Health Service for providing physicians, dentists, and other allied health personnel support to the Coast Guard is set forth in 42 USC, 253. These personnel are provided on a reimbursable basis and are subject to Coast Guard regulations and the Uniform Code of Military Justice (UCMJ).
3. Health and Safety Division, Maintenance and Logistics Commands MLC (k).
- a. Mission. The mission of MLC (k) is to:
- (1) interpret and implement health care policies as set forth by the Commandant;
  - (2) develop and implement the Coast Guard's overall Health Services, and Safety and Environmental Health Programs for the Area; and
  - (3) serve as Health Care Advisor to Commander, Maintenance and Logistics Command.
- b. Functions and Responsibilities. Under the direction and supervision of the Commander, Maintenance and Logistics Command (MLC), the Chief, Health and Safety Division shall:
- (1) act as Medical Advisor to the Area commander in providing counsel and advice on:
    - (a) interagency and interservice agreements for health care of Coast Guard personnel;
    - (b) the significance of legislative matters affecting the Coast Guard health care program; and
    - (c) important developments in the Department of Defense which affect the Coast Guard health care program.
  - (2) serve as advisor to the Area commander in developing and implementing national defense emergency medical, health, and sanitation policies and plans;
  - (3) plan, develop, and administer a comprehensive health care program for all beneficiaries;
  - (4) develop health services mobilization requirements and support documents;
  - (5) review and act on requests for contract health care services;
  - (6) act as contract technical representative in reviewing health care contract proposals;
  - (7) administer the health care quality assurance program;
  - (8) administer the Safety and Environmental Health Programs;
  - (9) administer the Alcohol Abuse Prevention program;
  - (10) develop and implement pharmaceutical support services;



- (11) be responsible for providing funding for direct health care expenditures;
  - (12) be responsible for the general oversight of health care budgets;
  - (13) be responsible for the oversight of general clinic policy to include setting standards for clinic operations and prioritizing of clinic functions;
  - (14) designate clinics as catchment area patient management sites;
  - (15) maintain liaison with U. S. Public Health Service, the Department of Veterans Affairs and the health departments of the Department of Defense and other Federal agencies within you area of responsibility; and
  - (16) be responsible for the general oversight of the subsistence program by providing assistance to Coast Guard units (ashore and afloat) to ensure the maintenance of high quality food service operations.
- c. In addition, the MLC (k)s shall have the right, in coordination with unit commanding officers, to detail health services personnel (officer and enlisted, Coast Guard and Public Health Service) for special assignments including meeting short-term staffing needs.
4. Responsibilities of Commands with Health Care Facilities. Unit commanding officers shall be responsible for:
- a. oversight of clinic procurements;
  - b. ensuring adherence to policies, military regulations and general administrative procedures,
  - c. funding for administrative and non-health care expenditures for clinics;
  - d. maintenance, repair and general support of clinic facilities;
  - e. ensuring compliance with action items required by quality assurance site surveys; and
  - f. working with the appropriate MLC in fostering quality, productivity, and operating efficiencies.



## Section B.- Personnel.

1. General Duties of Medical Officers. The principal duty of medical officers is to understand and support the operational missions of the Coast Guard. Medical Officers include Physicians, Physician Assistants (PA/PYA), and Nurse Practitioners (NP) who are members of the Coast Guard or Public Health Service detailed to the Coast Guard. Medical officers are required to have appropriate certification or licensure while assigned to the Coast Guard. Physicians must have an unrestricted state license to practice medicine. See 1-B-11 for nurse practitioner and physician assistant credential requirements. Civilian medical practitioners (under contract to the Coast Guard or GS employees) assigned to a medical treatment facility are considered medical officers to the limits defined by the language of their contract and/or job description. Civilian medical practitioners who have a contract with the Coast Guard to see patients in their private offices are not considered medical officers for the purpose of this instruction.

### a. General Responsibilities.

- (1) Medical officers must keep informed in all fields of general and military medicine and shall:
  - (a) ensure the fitness for unrestricted worldwide duty of active duty personnel;
  - (b) provide health care for all eligible beneficiaries as authorized by applicable laws and regulations;
  - (c) make appropriate referrals of eligible beneficiaries following existing policy and regulation;
  - (d) treat sick and injured personnel;
  - (e) prevent and control disease;
  - (f) promote health;
  - (g) give advice on such matters as hygiene, sanitation, and safety;
  - (h) recommend duty status of active duty personnel and Coast Guard civil service employees;
  - (i) ensure that each patient is notified of results of all PAP smears, mammograms, biopsies, pregnancy tests, and all tests that are abnormal or whose results indicate a need to initiate or change treatment.
  - (j) thoroughly understand all operational missions of the unit, units within the local area, and the human factors involved in performing them;



- (k) ensure that personnel are physically and psychologically fit for duty and attempt to learn of any unusual circumstances which might adversely affect their proficiency;
  - (l) maintain an active interest and participate in the local unit's safety program, assist the safety officers in planning, implementing, and coordinating the unit safety program, and advise the command on safety issues;
  - (m) be thoroughly familiar with the types of personal protective and survival equipment carried at the unit. Assist the engineering officer in maintaining and issuing the equipment, and be familiar with the Rescue and Survival System Manual, COMDTINST M10470.10 (series);
  - (n) actively participate in the unit physiology training program to ensure that personnel are capable of coping with the hazards of mission performance by presenting lectures and demonstrations which include, but are not limited to:
    - 1 fatigue
    - 2 emergency medicine,
    - 3 survival,
    - 4 disorientation,
    - 5 night vision,
    - 6 stress, and
    - 7 drug and alcohol use and abuse.
  - (o) ensure that HSs who participate in EMT operations maintain their certification, knowledge and Health Services skills in EMT operations, physiology;
  - (p) provide Health Services refresher training on emergency procedures; and
  - (q) participate in a program of continuing education in operational medicine including familiarity with information published for other branches of the Armed Forces.
- (2) Medical officers act as medical members in physical disability evaluation cases.
  - (3) Medical officers are responsible for advising commanding officers on: health status of personnel; nutritional adequacy, food handling and preparation;



heating, ventilation, and air conditioning; housing; insect, pest, and rodent control; water supply and waste disposal; safety; items sold in exchanges, commissaries, and other CGES facilities; the physical fitness of personnel; and immunization standards.

- b. Physical Examinations. Medical officers shall conduct physical examinations in accordance with Section 3-C of this Manual and in cases involving disability evaluation be guided by the Physical Disability Evaluation System, COMDTINST M1850.2 (series), and the Department of Veterans Affairs Publication, Physician's Guide for Disability Evaluation Examinations.
- c. Reports to Command. Report injuries to, or deaths of, personnel; damage, destruction, or loss of health services department property; and any other important occurrence, to the officer of the day or other command official for entry into appropriate log. Report any suspected child/spouse abuse to the commanding officer, family advocacy representative, and local law enforcement/child protective agency in accordance with Family Advocacy Program, COMDTINST 1750.7 (series), and other local, state, or Federal law. Report patients in serious or critical condition to the commanding officer or officer of the day, together with the information needed to notify the next of kin. Death imminent procedures are contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series).
- d. Educational Measures. Conduct health education programs, including disseminating information about preventing disease and other subjects pertaining to hygiene and sanitation.
  - (1) Sexually Transmitted Diseases. Conduct or supervise the instruction of personnel regarding sexually transmitted diseases and advise them of the associated dangers.
  - (2) First Aid Instruction. Conduct or supervise a program which will ensure knowledge and ability in first aid.
  - (3) Occupational Medical Surveillance and Evaluation Program (OMSEP). Conduct or supervise a program to indoctrinate personnel in the various aspects of occupational health and the OMMP.
  - (4) Human Immunodeficiency Virus (HIV). Conduct or supervise the instruction of personnel regarding (HIV) and advise them of the associated dangers.
  - (5) Wellness. Conduct or supervise a program to emphasize the importance of life-styles in maintaining health.
  - (6) Human Services. Conduct or supervise the instruction of Health Services personnel to ensure they are aware of all the services available to maintain a state of well being for personnel.



- e. Cooperation With Other Agencies. Cooperate with Federal, state, and local agencies for preventing disease, reporting communicable diseases, and collecting vital statistics.
- f. Designated Supervising Medical Officer (DSMO). Medical officers assigned as “designated supervising medical officer” (DSMO) will assume clinical responsibility for the treatment provided by each health services technician in their clinic for whom they are responsible. Assignments shall be made in writing and signed by the DSMO’s commanding officer. Clinical supervision and accountability is defined as follows:
  - (1) during normal clinic hours, HS consultation with the DSMO as determined by that medical officer, review 20 percent of each day’s new patient encounters seen only by the HS, and review 100 percent of all patient encounters seen only by the HS who return with no improvements. (Ideally these reviews would include the patient’s presentation to the medical officer.) The DSMO shall countersign all records reviewed.
  - (2) outside normal clinic hours, direct or telephone consultations as determined by the DSMO or duty MO; and, the following working day, a review of 100 percent of all visits seen only by the HS. The DSMO or duty MO shall countersign all records reviewed.
- g. Designated Medical Officer Advisor (DMOA). Health Services Technicians on independent duty (IDTs) shall have a “designated medical officer advisor” (DMOA) identified. The DMOA shall provide professional advice and consultation to the IDT. The cognizant MLC (k) shall apportion units with IDTs to units with medical officers attached. The cognizant MLC (k) shall make changes as necessary and forward such information to the affected units and Commandant (G-WKH). At the unit level, assignments shall be made in writing (addressed to the DMOA) and signed by the DMOA’s commanding officer, with copies to the IDT unit and the cognizant MLC (k). Assignment letters shall be addressed to the specific individuals involved, and new letters shall be issued following a change of DMOA or IDT. Professional advice and consultation, in this instance, is defined as follows:
  - (1) Telephone or radio consultation regarding specific cases as necessary between the HS and the DMOA. This does not preclude consultation between the HS and another Coast Guard medical officer, a medical officer of the Army, Navy, Air Force, or USPHS, or a physician under contract to the Coast Guard whose contract provides for such consultations; and
  - (2) Treatment record review: At the end of each quarter, the commanding officer of the independent duty HS or his designee (cannot be the HS) shall select at random 15 health records which have at least one entry made by the HS during the previous quarter. For each of these records, copies shall be made of all SF 600 entries during the quarter. Copies of the SF-600's shall be sealed in an envelope and marked for the **DMOA's Eyes Only**. The copies are then forwarded to the DMOA for review. The DMOA shall review these record



entries according to established criteria for record review at his/her facility. Each record entry (copy) shall be annotated “reviewed,” dated, and stamped with the DMOA’s name and pertinent comments concerning the record entry. One copy of the reviewed record entries shall then be returned to the HS via the unit’s commanding officer. A second copy of the reviewed entries shall be retained by the DMOA. Both the HS and DMOA copies shall be retained at the respective commands for a period of three years, for MLC review during QA site surveys. The record review shall be discussed with the HS in the quarterly phone contact between the DMOA and the HS. The DMOA is encouraged to provide input to the unit CO or XO regarding the professional performance of the independent duty HS.

- (3) Review of MLC quality assurance site survey reports for the independent duty site: The DMOA and HS shall review the MLC quality assurance site reports for the site. They shall collaborate on the required written plan of corrective actions which must be submitted to the MLC following the site survey. The DMOA should also consult with the unit commanding officer regarding the findings of the survey report.
2. Duties of Senior Medical Officers. The senior medical officer attached to a unit is responsible to the commanding officer of the unit for the provision of health services. In addition to the general duties of a medical officer, the senior medical officer is responsible for:
  - a. performing those duties as prescribed in Coast Guard Regulations, COMDTINST M5000.3 (series) if designated by Commander, Coast Guard Personnel Command (CGPC) as division chief;
  - b. advising the commanding officer of any deleterious environmental health factors;
  - c. supervising any assigned PYA/PAs and NPs including, on a monthly basis, random review of approximately five percent of the PYA/PA/NP’s charts for adequacy and appropriateness of treatment rendered;
  - d. in the absence of a pharmacy officer, maintaining antidotes for narcotics and poisons and ensuring only properly trained personnel are assigned to the pharmacy;
  - e. acting as the commanding officer’s representative on local emergency planning boards, and, during emergencies or disasters, furnishing advice to the commanding officer, formulating plans, and helping civilian authorities meet health care needs;
  - f. managing the quality of health care services provided;
  - g. maintaining liaison with the hospital commander or senior medical officer of nearby (75 miles) USMTF’s;
  - h. acting as quality assurance technical supervisor for all contracted health services;



- i. ensuring efficient and effective use of all assigned medical officers and civilian consultants;
  - j. preparing, through training and experience, health services technicians for independent duty assignments;
  - k. recommending to the command a designated supervising medical officer (DSMO) for each HS who provides medical treatment to patients; and
  - l. convening medical boards as appropriate in accordance with Chapter 3, Physical Disability Evaluation System, COMDTINST M1850.2 (series)
  - m. ensuring that all ancillary service areas (e.g., laboratory, radiology, etc.) maintain adequate policy and procedures manuals;
  - n. in conjunction with the MLC, providing professional oversight and establishing qualifications standards and privileging for assigned personnel, including contract, reserve and student providers;
  - o. assigning personnel and ensuring position and billet descriptions are accurate and that credentials and privileging requirements are met;
  - p. within general Coast Guard and unit guidelines, determining the priority and range of services for each beneficiary group;
  - q. maintaining liaison with counterparts in MTF, USTF, VA and private sector facilities;
  - r. preparing performance appraisals for assigned staff;
  - s. reviewing and ensuring accuracy of Clinic Automated Management System (CLAMS) and other statistical and informational reports;
  - t. ensuring that appropriate training is conducted on a regularly scheduled basis;
  - u. ensuring active participation and compliance with the Quality Assurance Program;
  - v. ensuring strict adherence to current infection control procedures and standards;
  - w. keeping the division chief informed;
  - x. other duties assigned by the Chief, Health Services Division.
3. Duties of Flight Surgeons. In addition to fulfilling the general duties of medical officers, flight surgeons must:
- a. thoroughly understand all operational missions of the aviation unit and participate as a flight crew member as required on MEDEVACS and to meet the requirements as



set forth in the Coast Guard Air Operations Manual, COMDTINST M3710.1 (series);

- b. be familiar with the operational missions of other Coast Guard units in the local area;
- c. obtain a general understanding of the flight characteristics of the aircraft assigned to the unit and be thoroughly familiar with the human factors involved in pilot and crew member interaction with the aircraft;
- d. be familiar with the Air Operations Manual, COMDTINST M3710.1 (series), with specific emphasis on Chapter 6, Rescue and Survival Equipment; Chapter 7, Flight Safety; and the sections of Chapter 3 (Flight Rules) dealing with protective clothing and flotation equipment;
- e. ensure that aviation personnel are physically and psychologically fit for flight duty and attempt to learn of any unusual circumstances which might adversely affect their flight proficiency, this includes getting acquainted with each pilot and crew member;
- f. make recommendations to the commanding officer concerning the health status of aviation personnel, and in particular, only a flight surgeon or aviation medical officer (AMO) shall issue “up” chits, except as noted in Section 3-G-2;
- g. maintain an active interest and participate in the air station flight safety program and assist the flight safety officer in planning, implementing, and coordinating the station flight safety program, and advising the command on the aeromedical aspects of flight safety;
- h. participate as the medical member of Aircraft Mishap Analysis Boards and, when so assigned, be responsible for completing the Medical Officer’s Report in accordance with Chapter 2 of Safety and Environmental Health Manual, COMDTINST M5100.47 (series);
- i. be thoroughly familiar with the types and uses of personal pro-protective and survival equipment carried on aircraft at the unit [The flight surgeon shall assist in inspecting the equipment, shall advise the engineering officer and aviation survival members in maintaining and issuing the equipment, and shall be familiar with Rescue and Survival Systems Manual, COMDTINST M10470.10 (series)];
- j. actively participate in the unit aviation physiology training program to ensure that aviation personnel are capable of coping with the hazards of flight by presenting lectures and demonstrations which include, but are not limited to:
  - (1) fatigue,
  - (2) emergency medicine,
  - (3) survival,
  - (4) disorientation,



- (5) night vision,
  - (6) reduced barometric pressure,
  - (7) crash injury avoidance,
  - (8) stress, and
  - (9) drug and alcohol use and abuse.
- k. advise the command on MEDVAC operations:
- l. ensure that HSs who participate in aviation operations maintain their knowledge and skills in aeromedical physiology, and provide refresher training lectures and demonstrations to emergency medical technicians (EMTs) and health services technicians on emergency medical procedures; and
  - m. participate in a program of continuing education in aviation medicine including familiarity with information published for flight surgeons by other branches of the Armed Forces.
4. General Duties of Dental Officers. The principal duty of dental officers is to support the Coast Guard operational mission by determining each member's fitness for unrestricted duty on a worldwide basis. Coast Guard dental officers are assigned to perform duties as general dental officers. Exceptions will be authorized in writing by Commander, Coast Guard Personnel Command (CGPC).
- a. General Responsibilities.
- (1) Coast Guard dental officers must stay informed in all fields of general and military dentistry and be responsible for:
    - (a) ensuring the fitness for unrestricted duty of active duty personnel on a worldwide basis;
    - (b) providing dental care for all eligible beneficiaries as authorized by applicable laws and regulations (ensure non-enrollment in United Concordia or Delta Dental before providing covered services);
    - (c) preventing and controlling dental disease (this includes performing dental prophylaxis);
    - (d) promoting dental health;
    - (e) referring eligible beneficiaries for dental treatment per MLC (k) SOP;
    - (f) prioritizing the delivery of dental care to meet Coast Guard unit operational readiness requirements;



- (g) ensuring that patients with gingivitis or periodontal disease have the opportunity to receive follow up care;
  - (h) ensuring that results of all biopsies are received and reviewed by a dentist to ensure that the appropriate action is taken;
  - (i) ensuring that when dental externs are assigned to the clinic, that a protocol is developed detailing lodging and subsistence arrangements, types of procedures allowed, available population to be treated and supervising dental officer responsibilities. The protocol must be signed by the Commanding Officer and provided to all participating dental schools;
  - (j) ensuring that procedures for handling medical emergencies within the dental clinic are clearly written and emergency drills are practiced periodically; and
- b. Dental examinations. Dental officers shall conduct the dental examination portion of physical examinations in accordance with Chapter 3 of this Manual. Dental examinations shall be conducted as soon as practical on personnel who report for duty so as to determine the need for dental treatment and to verify their dental records. Annual Type 2 dental examinations shall be conducted on all active duty personnel collocated with dental examiners (i.e., Coast Guard DOs, DOD DOs, or civilian contract dentists).
  - c. Care of Mass Casualties. Dental officers shall be qualified to perform first aid procedures in order to treat or assist in treating mass casualties.
  - d. State Licensure. While assigned with the Coast Guard, dental officers are required to have an unrestricted state license to practice dentistry.
  - e. Continuing Education. Participate in a program of continuing training in operational medicine/dentistry including familiarity with information published for other branches of the Armed Forces.
5. General Duties of Senior Dental Officers. The senior dental officer is responsible for:
- a. performing duties outlined in Coast Guard Regulations, COMDTINST M5000.3 (series) if designated by Commander, Military Personnel Command as division chief;
  - b. conducting an organized preventive dentistry and dental health education program for all eligible beneficiaries;
  - c. preparing, through training and experience, health services technicians for independent duty assignments;
  - d. overseeing the preparation of reports, updating the dental clinic policy and procedures manual, and maintaining records connected with assigned duties;



- e. overseeing the overall working condition, cleanliness and infection control of the dental clinic, which includes sterilization procedures, dental supply, equipment, publications maintenance, and the establishment of a preventive maintenance program for dental equipment and supplies;
- f. maintaining custody, security, and records of the dispensing of dental stores including all controlled substances and poisons under the cognizance of the dental branch, and maintaining antidotes for narcotics and poisons;
- g. issuing prescriptions for, and supervising the dispensing of controlled substances used in the dental branch;
- h. maintaining custody, security, and records of precious metals dispensed and ensuring that precious metals are reclaimed as required and necessary forms are filed with the Department of Treasury;
- i. managing the quality of dental care services provided;
- j. in conjunction with the MLC (k), providing professional oversight and establishing qualifications standards and privileging for assigned personnel, including contract, reserve and student providers;
- k. assigning personnel and ensuring position and billet descriptions are accurate and that credentials and privileging requirements are met;
- l. within general Coast Guard and unit guidelines, determining the priority and range of services for each beneficiary group;
- m. maintaining liaison with counterparts in MTF, USTF, VA and private sector facilities;
- n. preparing performance appraisals for assigned staff;
- o. and reviewing and ensuring accuracy of CLAMS and other statistical informational reports;
- p. ensuring that appropriate training is conducted on a regularly scheduled basis;
- q. ensuring active participation and compliance with the Quality Assurance Program.
- r. ensuring strict adherence to current infection control procedures and standards;
- s. keeping the division chief informed;
- t. other duties assigned by the Chief, Health Services Division.



6. General Duties of Chief, Health Services Division. The Chief, Health Services Division will:
- a. act as an advisor to the commanding officer regarding all health related matters;
  - b. under the unit executive officer, carry out the plan of the day as it pertains to the Health Services Division;
  - c. ensure that clinic performs Supporting Clinic duties for units designated by the cognizant MLC in their area of responsibility (AOR) IAW this instruction, cognizant MLC Instructions and SOP, and other pertinent directives. These duties include but are not limited to the following:
    - (1) Ensure the medical/dental readiness of all active duty personnel within their area of responsibility. This includes the review of health records and correction of deficiencies issues such as:
      - (a) Immunizations
      - (b) physical examinations
      - (c) annual dental exams
      - (d) HIV testing
      - (e) DNA specimen submission
      - (f) tuberculosis testing
    - (2) Provide pharmacy oversight to designated units via collateral duty Pharmacy Officer.
    - (3) Provide prime vendor pharmaceutical services to designated units via collateral duty Pharmacy Officers.
    - (4) Provide prime vendor medical/surgery services to designated units.
    - (5) Ensure that a Designated Medical Officer Advisor program is in place for designated units. This should include CPR/Lifesaver training to designated individuals.
    - (6) Provide physical examination review (approval/disapproval) to designated units.
    - (7) Ensure that health care delivery is provided in a timely manner to units for which a clinic is designated as their primary management site.
    - (8) Provide health benefits advice to designated units.



- (9) Assist with nonfederal medical and nonfederal dental preauthorization processing for designated units.
- (10) Assist with nonfederal invoice processing for designated units.
- (11) Assist with the timely completion of Medical Boards.
- d. ensure the medical/dental readiness of all active duty personnel within their area of responsibility;
- e. review the division AFC-30 and AFC-57 budget submittals;
- f. be responsible for the allocation of resources (personnel, funds, space, and equipment) within the division;
- g. when directed by the command, represent the division at staff meetings and ensure timely dissemination of the information to division personnel;
- h. prepare performance appraisals as appropriate and ensure that performance evaluations for all health services personnel are prepared and submitted in accordance with current directives;
- i. review all division reports;
- j. be responsible for the division training program, including rotation of personnel assignments for training and familiarization, in the health care delivery system;
- k. oversee clinic policies, procedures and protocols for compliance with this Manual, COMDTINST M6000.1B, MLC Instructions and S.O.P, and other pertinent directives;
- l. provide oversight with regard to applicable Federal, state, and local statutes and regulations;
- m. seek opportunities for cost reduction and enhancement of patient care through billet conversions, resource sharing, contracting, etc.;
- n. designate a clinic Quality Assurance Coordinator and ensure that the QA program is carried out;
- o. proctor student extern programs;
- p. proactively support and promote the command wellness program;
- q. participate in health care initiatives with local/regional DOD delivery systems, under Headquarters and MLC guidance;
- r. oversee and promote work-life issues pertaining to health care;



- s. ensure strict compliance to current infection control procedures and standards;
  - t. serve as chair of the Patient Advisory Committee;
  - u. oversee DSMO and DMOA programs;
  - v. in coordination with their respective MLC (k), establish their clinic as a Patient Management Site for units within their area of responsibility;
  - w. And perform other duties as directed by the Commanding Officer.
7. General Duties of Pharmacy Officers. While assigned with the Coast Guard, pharmacy officers are required to have an unrestricted state license to practice pharmacy. Pharmacy officers shall ensure that medications are acquired, stored, compounded, and dispensed according to applicable Federal laws in their primary and collateral duty clinics. This includes the direct supervision and management of the following:
- a. dispensing and labeling of all drugs, chemicals, and pharmaceutical products;
  - b. maintaining signature files for all health care providers;
  - c. providing patient-oriented pharmaceutical services including monitoring for appropriate drug therapy, allergies, therapeutic duplication, and medication interactions. Significant patient interactions should be documented on the SF-600;
  - d. providing verbal and written patient medication counseling when appropriate;
  - e. maintaining routinely stocked items at levels consistent with anticipated usage between regularly scheduled procurements of pharmacy supplies and determining the most effective expenditure of funds;
  - f. ensuring that security measures are instituted to prevent unauthorized entrance into the pharmacy or misappropriation of pharmacy stock;
  - g. receiving, safeguarding, and issuing all controlled substances as the command-designated custodian of controlled substances;
  - h. ensuring adequate quality control of all pharmaceuticals locally compounded;
  - i. maintaining current drug information files and a reference library of pertinent textbooks and professional journals;
  - j. implementing the decisions of the Pharmacy and Therapeutics Committee and serve as secretary of that committee;
  - k. inspecting monthly all clinic stocks of drugs and biologicals;
  - l. developing and maintaining a formulary for local use by medical and dental officers;



- m. informing the clinical staff of new drug information, policy changes, or other pertinent data on drugs;
  - n. participate in a program of continuing education in pharmacy or related fields;
  - o. maintaining, updating, and documenting monthly inspections of poison antidote and emergency drug supplies;
  - p. providing technical advice to the unit concerning drug testing, substance abuse, and other pharmaceutical matters;
  - q. providing guidance and advice to the medical staff on current immunization requirements,
  - r. serving as a resource for designated therapeutic categories of medications as they relate to the Coast Guard Health Services Allowance Lists, Core formulary, HS Drug Formulary and other drug lists, and.
  - s. participate in a program of continuing training in operational medicine/pharmacy including familiarity with information published for other branches of the Armed Forces.
8. Maintenance and Logistics Command Pharmacy Officers. Under the general direction and supervision of the Chief, Quality Assurance Branch, MLC, the MLC pharmacy officer shall:
- a. plan, develop and implement, within the resources available, an MLC-wide pharmacy quality assurance program to:
    - (1) review and evaluate the delivery of pharmaceutical services in support of mission operations, implement established policies pertaining to pharmaceutical services, and recommend appropriate changes, and
    - (2) monitor pharmacy operations, via quality assurance site visits, financial monitoring, and other workload indicators to ensure optimum utilization of personnel and financial resources.
  - b. plan and administer the acquisition and distribution of pharmaceuticals:
    - (1) review, analyze, and recommend the most efficient and cost effective means for providing pharmaceutical services throughout the Area, including the financial resources to be allocated to each operating facility under MLC oversight;
    - (2) monitor the procurement of controlled substances by Coast Guard units within the Area;
    - (3) provide to MLC (kqa) a system for the random monitoring of drugs procured from nonfederal sources.



- c. serve as pharmaceutical consultant on pharmacology, pharmacy, and drug utilization and provide technical pharmacy expertise, assistance, and advice to the MLC Commander and command elements within the Area;
- d. provide guidance and advice regarding the evaluation, training, and justification for pharmacy personnel to meet operational needs of units within the Area;
- e. provide liaison or representation to regional Federal and professional pharmacy groups and committees; and
- f. administer and monitor the collateral duty assignments of pharmacy officers in their respective Area.

9. Environmental Health Officers.

- a. Duties: Environmental health officers are responsible for recognition, evaluation, and control of biological, chemical, physical, and ergonomic factors or stresses arising from the environment which may cause sickness, impaired health and well-being, or significant discomfort and inefficiency, property damage, or which could adversely affect the Coast Guard's industrial hygiene, pest management, radiological health, and sanitation. Specific responsibilities can include:
  - (1) planning, budgeting, implementing and directing an environmental health program to support commands within their geographic area of jurisdiction.
  - (2) conducting environmental health audits of Coast Guard facilities and operations in order to detect health hazards and noncompliance with applicable safety and environmental health laws, regulations, standards, and procedures. Facilities and operations include:
    - (a) work environments;
    - (b) storage, handling, treatment, and disposal of hazardous materials and hazardous waste;
    - (c) storage, handling, treatment, and disposal of infectious medical waste;
    - (d) food preparation, service and storage operations;
    - (e) solid wastes storage, handling, treatment, and disposal;
    - (f) pest management operations;
    - (g) potable water treatment, storage and distribution systems;
    - (h) waste water collection, treatment, and disposal system;
    - (i) housing facilities;



- (j) ionizing radiation sources;
  - (k) non-ionizing radiation sources;
  - (l) recreational facilities;
  - (m) health care facilities;
  - (n) child care facilities;
  - (o) laundry and dry-cleaning operations; and
  - (p) barber shop operations
- (3) providing technical assistance to units to abate deficiencies identified by the environmental health officer during the audit.
  - (4) monitoring ongoing hazard abatement actions to ensure that identified hazards are being eliminated promptly.
  - (5) providing environmental health training to commands within their jurisdiction.
  - (6) providing technical assistance to units on request to identify and abate health risks.
  - (7) reviewing engineering plans and specifications for new facilities and modifications to existing facilities to ensure conformance with environmental health standards and practices.
  - (8) serving as technical advisor to commands within their jurisdiction.
  - (9) initiating and conducting special health risk assessment studies.
  - (10) maintaining liaison with Federal, state, and local government agencies concerning environmental health for commands within their jurisdiction.
  - (11) advising commands when medical monitoring data indicates the possibility of occupationally-induced or aggravated disease and investigating possible causes so that corrective measures can be initiated.
  - (12) providing consultation, advice, and training on the occupational medical monitoring program to Coast Guard commands within their area of jurisdiction.
  - (13) enrolling personnel in the OMSEP when they meet the criteria of occupational exposure as defined in paragraph 12-A-2.
  - (14) disenrolling personnel from the OMSEP when they do not meet the criteria of occupational exposure as defined in paragraph 12-B-4.
- b. Reports. Environmental health officers shall submit reports to the appropriate MLC (k) about environmental health conditions observed during their surveys.



- c. Duty Limitations. Environmental health officers shall carry out all management functions required to operate the safety and environmental health program within their AOR. They may be required to perform only those technical duties for which they are trained. They may represent health services at various staff meetings in matters relating to the management and budgetary aspects of their assignment. They will be primarily responsible for special studies as in the case of monitoring chemical spill response and enforcement personnel. They will be responsible to the Commander, MLC (k) for proper implementation of the safety and environmental health program.
10. Clinic Administrators. Officers, Chief Warrant Officers (experience indicator 19), or senior enlisted personnel assigned to manage and administer health care facilities.
- a. Under the direction of the Chief, Health Services Division, manage the administrative functions required to operate the health care facility. The Clinic Administrator will not be required, nor attempt, to perform clinical duties for which he/she is not trained.
  - b. General Responsibilities. The Clinic Administrator will:
    - (1) plan, supervise, and coordinate general administration of the health services facility;
    - (2) prepare, submit, manage, and exercise fiduciary control and accountability over the health services division AFC-30 and AFC-57 funds;
    - (3) provide fiscal oversight over the acquisition of equipment and supplies;
    - (4) maintain a planned program of equipment maintenance and replacement;
    - (5) provide physical security of health services division supplies and pharmaceuticals;
    - (6) maintain liaison with other local agencies (military and civilian) in all health care related matters;
    - (7) provide resources to assist medical and dental officers in emergency care of the sick and injured when necessary;
    - (8) prepare the disaster preparedness plan as it relates to the health services division;
    - (9) prepare the heavy weather bill as it relates to the health services division;
    - (10) seek opportunities for cost reduction and enhancement to patient care through billet conversions, resource sharing, contracting, etc.;
    - (11) serve as an advisor to the chief, health services division on all administrative matters;
    - (12) oversee the supervision of enlisted personnel assigned to the health services division;



- (13) ensure that correspondence, reports, and records comply with appropriate instructions (i.e. Paperwork Management Manual, Coast Guard Correspondence Manual, etc.);
- (14) maintain an adequate health services division reference library;
- (15) train subordinates, conduct classes, instruct enlisted personnel in their duties, and supervise their study of regulatory and professional publications and courses for advancement in rating;
- (16) participate in a program of continuing education in Health Care Administration;
- (17) assist beneficiaries with health benefits information;
- (18) enforce standards of appearance and conduct of health services division personnel;
- (19) ensure that accurate, appropriate data is submitted to the CLAMS information system, CHCS system, etc.;
- (20) oversee clinic rotation assignments of Health Services Technicians;
- (21) implement clinic policies, procedures, and protocols, for compliance with Coast Guard regulations, the Medical Manual, MLC INST/SOP, and other pertinent directives;
- (22) ensure compliance with all applicable Federal, state, and local statutes, together with the medical, dental and pharmacy officers;
- (23) oversee and promote work-life issues pertaining to health care
- (24) serve as assistant chair for the Patient Advisory Committee;
- (25) ensure that enlisted personnel evaluations for members assigned to the health services department are prepared and submitted in accordance with the Coast Guard Personnel Manual;
- (26) provide administrative oversight in the areas of NONFED health care, contracts, and BPAs;
- (27) ensure that health care invoices are processed in accordance with MLC INST/SOP;
- (28) ensure that physical examinations comply with current standards;
- (29) promote and administer the unit's environmental sanitation program (in the absence of an environmental health officer); and
- (30) oversee the unit's Occupational Medical Surveillance and Evaluation Program (OMSEP), in the absence of an environmental health officer.



11. Physician Assistants (PA/PYA(s)) and Nurse Practitioners (NP).

- a. General Responsibilities. PA/PYA(s) and NP(s) responsibilities are defined in Section 1-B-1. Under the supervision of the senior medical officer they are subject to the duty limitations listed below.
- b. Duty Limitations.
  - (1) Senior Medical Officers (SMO) of units with mid-level providers (physician assistants or nurse practitioners) assigned shall assign clinical duties and responsibilities to each provider and shall be accountable for the actions of those providers.
    - (a) To determine the extent of oversight required, SMOs shall be guided by this section, the provider's clinical training and previous experience, by personal observation, and Chapter 13-C, Clinical Privileges.
    - (b) The SMO may delegate supervisory responsibility to another staff physician or certified mid-level provider (mentor). A copy of this delegation shall be filed in the non-certified provider's Professional Credentials File (PCF).
    - (c) Physicians responsible for supervising mid-level providers shall perform and document reviews of at least five percent of the mid-level provider's charts each calendar month for accuracy of diagnosis and appropriateness of treatment rendered.
  - (2) Physician assistants who are not certified by the National Commission on Certification of Physician Assistants (NCCPA), recent graduates who have not taken or passed the NCCPA examination, and nurse practitioners who have not taken or passed a specialty board examination offered by the pertinent nurse practitioner certifying organization, shall practice in Coast Guard facilities only under the following conditions:
    - (a) all health record entries shall be co-signed by a licensed or certified provider by the end of the next working day;
    - (b) all prescriptions, except for those on the Coast Guard HS formulary, shall be co-signed by a licensed or certified provider by the end of the next working day;
    - (c) when a supervisory provider is not present at the unit, noncertified mid-level providers shall be restricted to providing medical care, except for emergencies, to active duty members only;



- (d) noncertified mid-level providers may stand clinic watches providing a standby licensed or certified provider is available via telephone to discuss any questions or concerns; and,
  - (e) with the exception of operational emergencies, noncertified mid-level providers are not eligible for independent TAD assignments at locations where a supervisory provider is not present.
- c. Nothing in this section limits PA/PYA's or NP's access to any available source of information or advice during an emergency.

12. TRICARE Management Activity-Aurora (TMA) Liaison Officer.

- a. Responsibilities. The Coast Guard TMA liaison officer maintains liaison between TRICARE and Commandant (G-W) on matters of policy, operations, and program administration. This function will not involve the responsibility for formulating department policies. Departmental policies will continue to be developed by members of the liaison group for the Uniformed Services Health Benefits Program.
- b. Duties.
  - (1) Specific Duties. Specific duties include, but are not limited to the following:
    - (a) coordinate and assist, as necessary, in preparing and submitting uniform workload data for use in budgetary programming at departmental level;
    - (b) ensure timely notification to Commandant (G-W) concerning changes in TRICARE operational or administrative procedures;
    - (c) identify gaps in the TRICARE information program and recommend solutions;
    - (d) represent Coast Guard viewpoints on matters relating to TRICARE operational and administrative procedures;
    - (e) assist in developing future TRICARE information programs;
    - (f) keep the Coast Guard informed of problem areas relating to service beneficiaries and service health care facilities, where appropriate, and recommend changes which will benefit the TRICARE operation; and
    - (g) monitor purchases of high-cost equipment for use by TRICARE beneficiaries and make recommendations concerning future purchases as opposed to rental.
  - (2) Duties within TMA Liaison Division.



- (a) Investigate and respond to Presidential, Congressional, and beneficiary inquiries and complaints. Investigate and respond to inquiries concerning eligibility.
- (b) Make public presentations concerning program benefits to various groups.
- (c) Prepare special studies relating to program activities.
- (d) Serve as liaison representative for USPHS, DVA, and NOAA.
- (3) Other Duties. Participate in contract performance appraisal visits to the fiscal administrators. This function involves a comprehensive review and evaluation of the operations of the civilian agencies which, under contract, administer the program within each region.

13. Health Services Technicians.

- a. Rating Structure. The rating structure for health services technicians is contained in Group VIII, Enlisted Qualifications Manual, COMDTINST M1414.8 (series).

- b. General Duties of Health Services Technicians.

- (1) The primary purpose of a health services technician is to provide supportive services to medical and dental officers and primary health care in the absence of such officers. In accordance with Paragraph 7-5-4, Coast Guard Regulations, COMDTINST M5000.3 (series), health services technicians shall not be detailed to perform combatant duties.
- (2) In particular, health services technicians are responsible for all administrative aspects of health care and health record maintenance for both their command and subordinate commands without health services personnel attached. Geographically separate subordinate commands will retain responsibility for security (i.e. physical custody) of health records. In addition to the military duties common to all enlisted personnel, health services technicians perform health services department functions, such as:
  - (a) respond to calls for emergency medical assistance or evacuations (MEDEVACS);
  - (b) maintain appointments and appointment records;
  - (c) perform occupational medical monitoring duties;
  - (d) render first aid;
  - (e) perform tentative diagnosis and emergency treatment (In doing so, appropriate drugs, oral or injectable, may be administered as required in emergency situations to prevent or treat shock or extreme pain. In all



other incidents where injection of controlled substances is required, permission must be obtained from a physician prior to administration. In either case, the commanding officer shall be notified immediately and entries shall be made in the patient's health record.);

- (f) provide nursing care where trained;
  - (g) provide definitive treatment;
  - (h) provide prophylactic treatments;
  - (i) instruct crew members in first aid and oral hygiene;
  - (j) prepare materials (including sterile instruments) and medications for use;
  - (k) maintain military readiness of the health services division by complying with the appropriate Health Services Allowance List;
  - (l) perform administrative procedures in health care matters, maintain health and dental records current in all aspects;
  - (m) adhere to regulations, instructions, and control of precious metals, controlled substances, and poisons;
  - (n) exercise responsibility for all equipment and stores placed in their charge, and exercise personal supervision over their condition, safekeeping, and economic expenditure;
  - (o) maintain cleanliness of all health services spaces;
  - (p) provide services as a health benefits advisor; and
  - (q) assist in the processing of nonfederal health care requests and invoices.
- (3) Each HS who provides medical treatment to patients at a Coast Guard clinic staffed by one or more medical officers shall have a medical officer from that facility assigned in writing as his/her designated supervising medical officer (DSMO). The DSMO shall assume responsibility for all clinical treatment provided by the HS. Each independent duty HS, and HSs assigned to clinics without a medical officer, shall have a medical officer assigned in writing as his/her "Designated Medical Officer Advisor" (DMOA), to provide professional advice and consultation when needed. Refer to 1-B-1.f. and 1-B-1.g. for further details concerning DSMO/DMOA. Health services technicians assigned to units without a medical officer shall provide only "first response" emergency care to non-active duty personnel.
- (4) Care shall be taken during medical examinations which involve chest, genital, and rectal areas to afford maximum privacy and minimum exposure of the



patient. An attendant of the same gender as the patient may be requested by the patient during examination or treatment. Health services technicians are authorized to conduct examinations to include: auscultation, palpation, percussion, and visual inspection as indicated by the medical complaint. Exceptions to the above are:

- (a) health services technicians shall not perform:
    - 1 routine digital examinations of the prostate;
    - 2 routine examinations through instrumentation of the urethra; or
    - 3 routine gynecological examinations.
  - (b) such routine examinations shall be referred to a medical officer. In situations where no medical officer is readily available and such examination is necessary to provide emergency care, the health services technician is authorized to do so. If the HS and patient are of different gender, an attendant of same gender as the patient shall accompany the patient during the examination or treatment.
- (5) Participate in a course of continuing education, either clinical or administrative, through correspondence courses, resident courses, etc.

14. Health Services Technicians - Dental (HSDs).

- a. The primary responsibility of HSDs is to provide chairside assistance to dental officers.
- b. Additional duties include:
  - (1) Cleansing, sterilization, maintenance, and preparation of dental instruments;
  - (2) Cleansing, disinfecting, and maintenance of dental equipment and dental operatories;
  - (3) Preparing of dental materials;
  - (4) Assessing, referral, and treatment (under direct supervision of a dental officer) of common dental conditions;
  - (5) Charting dental conditions;
  - (6) Maintaining dental records;
  - (7) Exposure and development of dental radiographs;
  - (8) Providing oral hygiene instruction;
  - (9) Taking impressions and fabricating study models; and
  - (10) Performance of emergency intervention as necessary.



- c. HSDs may be assigned to supplement HS duty sections, HSDs may not stand watch independently.

15. Independent Duty Health Services Technicians.

a. Duties.

(1) General Duties.

- (a) Health services technicians on independent duty perform the administrative duties and, to the extent for which qualified, the clinical duties prescribed for medical officers of vessels and stations. (See Coast Guard Regulations, COMDTINST M5000.3 (series) and Section 1-B of this Manual.) They shall not attempt nor be required to provide health care for which they are not professionally qualified. They shall provide care only for active duty personnel, however they may provide care to non-active duty patients on an emergency basis. The filling of prescriptions for other than active duty personnel shall be strictly limited to emergency situations and to authorized stock on hand under the allowance list for the unit. They may, under the guidance set forth in Paragraph 10-A-6-h. of this Manual, establish non-prescription medication handout programs for eligible beneficiaries.
- (b) Health services technicians shall not be detailed to perform combatant duties in accordance with Paragraph
- (c) 7-5-4, Coast Guard Regulations, COMDTINST M5000.3 (series).
- (d) In accordance with the Personnel Manual, COMDTINST M1000.6 (series), commanding officers are authorized to use health services technicians for general duties except noted below:
  - 1 Health services technicians shall not be used for duties that require bearing arms (except for the limited purposes allowed by the Geneva Convention for their own defense or protection of the wounded and sick in their charge) even though the bearing of arms may be purely ceremonial.
  - 2 Health services technicians shall not be used for combat duties that are unrelated to health care or administration.

(2) Specific Duties.

- (a) Sanitation of the Command. Make daily inspections to ensure that appropriate sanitation practices are maintained.
- (b) Health of Personnel. Establish and maintain a system for determining those who need immunizations, tuberculin tests, X-rays, dental services,



and routine physical examinations. The system shall include all return appointments requested by physicians or dentists from outside referrals requested by the command.

- (c) Care of Sick and Injured. Hold daily sick call. Diagnose and treat patients within capabilities. When indicated, refer cases to facilities where medical or dental officers are available or, if this is not practical, obtain help and advice by radio or other expeditious means.
- (d) Procurement, Storage, and Custody of Property. All parts of the Health Services Allowance List (HSAL) Afloat, COMDTINST M6700.6(series), and Health Service Allowance List Ashore, COMDTINST M6700.5 (series) contain information needed for ordering and procuring supplies. The HSAL also contains procedures for storage and custody of property.
- (e) Reports. Prepare and submit reports required by Chapter 6 of this Manual and other directives.
- (f) Health Records. Maintain health records as required by Chapter 4 of this Manual. Ensure that all treatment records and/or consults from outside referrals are obtained and placed in the health record. In addition, ensure that each patient is notified of all physical exams, consultations, and diagnostic tests (i.e., pap smears, mammograms, biopsies, x-rays, etc.) performed at any facility prior to filing in the health record.
- (g) Training. Prepare and carry out a program for training non-medical personnel in first and self-aid, personal hygiene, sexually transmitted disease prevention, medical aspects of CBR warfare, cardiopulmonary resuscitation, etc., as part of the unit's regular training program.
- (h) Other Duties. As assigned by the commanding officer.

b. Reporting Procedures.

- (1) Policy. Upon reporting for independent duty, the health services technician shall consult with the commanding officer and executive officer to determine their policies regarding health care and the administration of the health services department.
- (2) Inventory. Obtain the unit Health Services Allowance List and inspect the inventory of all health services department equipment, supplies, and publications. Initiate action for repair, survey, or replenishment of equipment, supplies, and publications. Verify inventory records and check logs of controlled substances. Report any discrepancies to the commanding officer without delay. Amplification of requirements and procedures is contained in Chapters 8 and 10 of this Manual.



- (3) **Health Records.** Check health records against the personnel roster. Any missing records should be accounted for or requested from previous duty stations. If records cannot be accounted for within one month's time, open a new health record. Check health records for completeness, and if not current, obtain and enter all missing information to the fullest extent possible. (See Chapter 4 of this Manual for instructions pertaining to health records.)
  - (4) **Operational Readiness.** Ascertain the state of operational readiness of the health services department and advise the commanding officer. Operational readiness refers to the immediate ability to meet all health care demands within the unit's capabilities.
- c. **Responsibilities.** The commanding officer is responsible for the health and readiness of the command. The health services department is charged with advising the commanding officer of conditions existing that may be detrimental to the health of personnel and for making appropriate recommendations for correcting such conditions. Meticulous attention to all details and aspects of preventing disease must be a continuing program. It is imperative that shipboard and station sanitation and preventive health practices be reviewed constantly in order that any disease promoting situation may be discovered immediately and promptly eradicated.
- d. **Routines.**
  - (1) **Daily Routines.**
    - (a) **Sickcall.** Hold sickcall daily at a time prescribed by the commanding officer.
    - (b) **Binnacle List.** Prepare the unit Binnacle List and submit it to the commanding officer. (See section 6-B of this Manual for instructions pertaining to the Binnacle List.)
    - (c) **Inspections.** The following shall be inspected daily:
      - 1 coffee messes;
      - 2 living spaces;
      - 3 heads and washrooms;
      - 4 fresh provisions received (particularly milk and ice cream);
      - 5 scullery in operation;
      - 6 drinking fountains;
      - 7 garbage disposals;



- 8 sewage disposals;
    - 9 water supplies;
    - 10 and industrial activities. (See Chapter 7 of this Manual and the Food Service Sanitation Manual, COMDTINST 6240.4(series)).
  - (d) Testing of Water. Perform water tests for chlorine/bromine content daily outside of CONUS and at all units that make or chlorinate/brominate their own water and record the results in the Health Services Log. Consult the Water Supply and Wastewater Disposal Manual, COMDTINST M6240.5 (series).
  - (e) Cleaning. Health services department spaces shall be cleaned daily and all used instruments cleaned and stored until sterilization can be accomplished.
- (2) Weekly Routines.
- (a) Health Services Logs. A health services log shall be kept by all activities and shall be submitted to the commanding officer for review, approval, and signature. Section 6-B of this Manual contains the information needed for maintaining the log.
  - (b) Inspections. Conduct sanitation inspection of the ship or station with emphasis on food service, living spaces, and sanitary spaces, specifically including food handlers, refrigerators and chill boxes, and galley spaces and pantries. Submit a written report to the commanding officer and make an appropriate entry in the health services log.
  - (c) Training. Conduct training in some aspect of health care or treatment unless required more frequently by the commanding officer or other directive.
  - (d) Hold field day.
  - (e) Resuscitators. Inspect and test resuscitators to ensure proper functioning. Record results in the health services log.
- (3) Monthly Routines.
- (a) Reports. Submit all required health services monthly reports, outlined by Chapter 6 of this Manual and other appropriate directives.
  - (b) Inspection of Battle Dressing Station Supplies. Monthly, inspect battle dressing station supplies to ensure adequate and full inventory. Check sterile supplies and re-sterilize every six months (refer to Health Services Allowance List Afloat, COMDTINST M6700.6 (series). Replace



expired or deteriorated supplies and materials. Enter an appropriate entry in the health services log indicating that the inspection was conducted and the action taken.

- (c) First Aid Kits. Inspect hinges and hasps to ensure that they are free from rust, corrosion, or excessive paint.

(4) Quarterly Routines.

- (a) Inventory of Controlled Substances. The Controlled Substances Inventory Board shall conduct an inventory, as required by Chapter 10 of this Manual, and submit a written report of the findings to the commanding officer.
- (b) Reports. Submit all required health services reports as outlined in Chapter 6 of this Manual and other appropriate directives.
- (c) Inventory. Conduct a sight inventory of all health services consumable supplies/equipment as required by Chapter 8 of this Manual and the Health Services Allowance List.
- (d) First Aid Kits. Inspect the contents to ensure adequate and full inventory. Replace expired and deteriorated supplies and materials. Make an appropriate entry in the health services log.

16. Coast Guard Beneficiary Representatives at Uniformed Services Medical Treatment Facilities (USMTF).

- a. Duties. Health Services Technicians may be detailed to duty as representatives at USMTF's where the Coast Guard patient workload warrants. The purpose of these assignments is to ensure, for active duty personnel:
  - (1) that Coast Guard authorities are provided prompt and current information concerning the status of Coast Guard personnel being treated;
  - (2) that Coast Guard personnel being treated receive necessary command administrative support;
  - (3) that the USMTF use the patient's Coast Guard health record and that entries are made in it or on forms that are filed in it; and
  - (4) that necessary health records and forms either accompany the patient or are forwarded to the command having custody of the health record.
- b. Responsibilities. The representative is responsible for the following:
  - (1) Notification of Patient Status. It is essential that the representative keep cognizant command levels advised of the status of Coast Guard patients admitted for inpatient treatment. The following procedures shall be used:



- (a) notify commands, by the most expedient means possible, within 24 hours of admission or discharge of members of their command.
- (2) Health Record Entries. The representative is responsible for ensuring that all information concerning inpatient hospitalization, (e.g., admissions, operative summaries, discharge summaries) which is required to be entered in the health record, is furnished to the command which maintains the patient's health record. The representative shall also make the USMTF aware that all entries or forms associated with outpatient medical and dental activity must be entered in the patient's Coast Guard health record.
- (3) Copies of Forms. The USMTF is responsible for completing and furnishing at least one copy of the following forms to the representative. The representative is responsible for preparing any additional copies needed.
  - (a) Inpatient hospitalizations:
    - 1 SF-502, Narrative Summary (or other discharge summary form), and
    - 2 Operative summary if surgery was done.
  - (b) Physical examinations:
    - 1 SF-88, Report of Medical Examination.
    - 2 SF-93, Report of Medical History.
    - 3 ANY specialty reports obtained pursuant to the physical examination.
  - (c) Initial and Disposition Medical Boards:
    - 1 NAVMED 6100/1, Medical Board Report Cover Sheet;
    - 2 SF-88, Report of Medical Examination;
    - 3 SF-93, Report of Medical History;
    - 4 SF-502, Narrative Summary;
    - 5 ANY specialty reports obtained pursuant to the physical examination;
    - 6 CG-4920, Patient's Statement Regarding the Findings of the Medical Board, signed by the patient;
    - 7 The command endorsement, Line of Duty/Misconduct Statement (if any), and members rebuttal (if any) should normally be done at/by the command.



- (4) Liaison and Assistance. The representative shall:
  - (a) Maintain liaison between the Coast Guard units in the area and the USMTF as follows:
    - 1 Clinical services to obtain timely appointments for Coast Guard personnel;
    - 2 Pharmacy to facilitate drug exchange with Coast Guard units; and
    - 3 Biomedical repair to help originate and maintain agreements for repair and maintenance of local Coast Guard medical equipment.
  - (b) Whenever possible, personally meet with each hospitalized Coast Guard active duty member and meet or phone the immediate family of the member, offering them assistance.
  - (c) In appropriate cases, channel other Coast Guard and DOD resources such as Mutual Assistance, Family Programs, Red Cross, etc. to assist hospitalized members and their dependents.
- (5) Assignment and Duties. Health Services technicians assigned to a USMTF as Coast Guard Beneficiary Representatives are attached to MLC (k) which will exercise military control over them. The representative is expected to comply with the rules and orders of the USMTF to which assigned, and is subject to the orders of the hospital commander. However, it is expected that any duties assigned will be consistent with the purpose noted in subparagraph 13a. above.

17. Coast Guard Representative at the Department of Defense Medical Examination Review Board (DODMERB).

- a. General. DODMERB is located at the USAF Academy, CO and is a joint agency of the military departments responsible for scheduling, reviewing, and certifying service academy and ROTC scholarship applicant medical examinations, and other programs assigned by the Office of the Assistant Secretary of Defense, Health Affairs.
- b. Responsibilities.
  - (1) As a member of DODMERB, the Coast Guard:
    - (a) establishes entrance standards for the Coast Guard Academy; and
    - (b) makes its health care facilities available for completing entrance physical examinations for all service academies.
  - (2) As a member of DODMERB, the Coast Guard liaison:
    - (a) is assigned as an examination evaluator/administrator; and



- (b) participates in implementing plans and organizational procedures for board actions.

c. Duties.

- (1) Maintain a current list of examining centers which includes dates and examination quotas.
- (2) Schedule examinations for the applicants.
- (3) Notify applicants and program managers of scheduled examinations.
- (4) Review and apply medical standards.
- (5) Notify applicants and program managers of the status and qualifications of applicants.
- (6) Provide copies of medical examinations and medical information to the various programs on applicants until they are no longer eligible.
- (7) Provide copies of medical examinations and medical information to eligible applicants as requested.

18. Health Benefits Advisors (HBA).

- a. Responsibilities. Individuals designated as Health Benefits Advisors (HBAs) at CGMTFs are responsible for advising and assisting beneficiaries concerning their health benefits. This individual shall:
  - (1) keep current on the TRICARE Program, Uniformed Services Family Health Benefits Program (USFHB) and on all other health benefits programs available for members, former members, and their eligible dependents;
  - (2) advise all beneficiaries on matters pertaining to healthcare benefits, including;
    - (a) obtaining Nonavailability Statements,
    - (b) using the local appeal system for Nonavailability Statements, and
    - (c) conducting a local information program on healthcare benefits;
  - (3) advise TRICARE beneficiaries on the relationship between TRICARE, DVA programs, Social Security, Medicare, insurance provided through employment, and the effect of employment and private insurance on benefits available under TRICARE:
    - (a) stress availability of TRICARE and explain financial implications of using non-participating providers,
    - (b) explain provider participation in TRICARE and explain financial implications of using non-participating providers,



- (c) provide beneficiaries the names and addresses of participating providers of the specific services the beneficiary requires, and
- (d) caution beneficiaries to verify that the provider participates in TRICARE at the time the services are provided;
- (4) coordinates TRICARE problem cases with MLC HBAs, TRICARE contractors and the Coast Guard liaison officer at TMA-Aurora when required;
- (5) assist beneficiaries in properly completing TRICARE claim forms;
- (6) serve as a single point of contact for all health benefits programs available to active duty and retired members and their dependents;
- (7) provide information and assistance based upon personal, written, or telephone inquiries concerning healthcare benefits;
- (8) keep beneficiaries informed of changes within the various programs, e.g., legislative changes affecting benefits available or other policy/procedures impacting upon the usage of civilian medical care. Provides for an ongoing program of lecture services, informational seminars, and group counseling to various beneficiary groups, service clubs, retirement briefings, etc.;
- (9) maintains liaison with local providers and encourages them to increase their acceptance of the TRICARE program, and;
- (10) maintains liaison with cognizant MLC HBA, and unit collateral duty HBAs in local area.

b. Training.

- (1) Individuals designated as HBAs must be trained in TRICARE benefits, exclusions, claims preparation, processing, cost sharing formulas, eligibility criteria, and alternatives to TRICARE.
- (2) Training Schedule.
  - (a) Requests for attendance at the TRICARE course should be submitted via the Chain of Command to the CG TRICARE Liaison Officer at TMA-Aurora.
  - (b) TRICARE course registration form is available at <http://www.TRICARE.osd.mil>. This form may be submitted electronically or by mail.
- (3) TMA-Aurora Liaison Staff Seminars. The Liaison Office at TMA-Aurora provides seminars for large beneficiary groups, e.g., recruiter, career counselor, etc. Arrangements for seminars should be made directly with CG Liaison.
- (4) Funding. Training requests for the TRICARE course will be funded by the cognizant unit, MLC, or Headquarters component.



- c. Sources of Reference Materials. HBAs shall acquire and become familiar with specific reference materials on Federal and nonfederal health programs. Specifically, as TRICARE policies change, the HBA shall maintain an updated reference library through distribution channels as outlined below:

- (1) TRICARE Information.
- (2) Contact: Coast Guard Liaison Officer  
Commercial: (303) 676-3538  
Website: <http://www.TRICARE.OSD.MIL>

Coast Guard Headquarters Distribution.  
Stock Point: Commandant (G-WKH-3)  
Via: Rapidraft Letter  
Tel: (COMM) (202) 267-0846

TRICARE Standard Handbook 6010.46-H

- (3) TRICARE Claim Forms (DD-2642, OCT93)  
Now available at Website: <http://www.TRICARE.OSD.MIL> or by contacting:

Stock Point: Navy Publications and Forms Center  
5801 Tabor Avenue  
Philadelphia, PA 19120  
U/I: PD

- (4) Referral for Civilian Medical Care (DD-2161).

May be printed locally by accessing CG Standard Workstation III, Jetform Filler Database or by contacting:

Stock Point: Navy Publications and Forms Center  
5801 Tabor Avenue  
Philadelphia, PA 19120  
U/I: PD

- (5) Fiscal Intermediary Distribution by Region. Fiscal Intermediary Newsletter
- (6) Local Community. Local Publication - Social Services Directory

19. Dental Hygienists. Dental hygienists are licensed graduates of American Dental Association accredited schools of dental hygiene. Whether contract or active duty providers, they are authorized to treat beneficiaries in Coast Guard dental clinics under the oversight of a dental officer. Restrictions on the degree of required oversight and the scope of services vary from state to state.

- a. In the interests of standardization, quality assurance, and risk management, dental hygienists in Coast Guard health care facilities shall, in most circumstances, treat patients only when a dental officer is present for duty at the command. At the



discretion of the SDO, and in the interest of expediency, this guideline may be overridden if each of the following conditions is met on each patient:

- (1) Only active duty members are treated;
  - (2) A medical officer is present in the building;
  - (3) Patients' Periodontal Screening and Recording (PSR) scores are 10 or less; and
  - (4) The licenses of the SDO and dental hygienist are not jeopardized by this action.
- b. In every case, patients must receive a Type 2 examination by a dental officer no more than six months prior to treatment by a dental hygienist.
  - c. The Senior Dental Officer (SDO), or a staff dental officer designated by the SDO, shall review no fewer than 5% of the dental hygienist's patients for completeness of plaque/deposit removal and damage to hard/soft tissues. The responsible dental officer shall document these reviews in the patients' dental records.
  - d. The scope of the dental hygienist's services shall be governed by either the state in which the license is held or the state in which the clinic is located, whichever is more restrictive, and shall be itemized in the clinic's Standard Operating Procedures (SOP).
  - e. In some cases the state license may contain an addendum certificate which "privileges" the dental hygienist to administer injections of local anesthesia under the direct oversight of a licensed dentist. If the state in which the clinic is located also allows this, then the dental hygienist may deliver local anesthesia under the direct oversight of the dental officer. In all cases, the dental hygienist must possess specific credentials from the state of licensure allowing him/her to administer local anesthesia. "Direct oversight" shall mean that the dental officer personally has authorized the dental hygienist to administer local anesthesia to the specific patient being treated at the specific time (i.e., "blanket approvals" are not authorized). The dental officer shall be physically present in the clinic while local anesthesia is administered by the dental hygienist. While direct oversight does not require the dental officer to be physically present in the dental hygienist's operatory, the dental officer must be in the clinic and be capable of responding to an emergency immediately.
20. Red Cross Volunteers. Red Cross Volunteers are persons who have completed a formal training program offered by a Red Cross Chapter and have a certificate of successful completion. Red Cross training is a screening and educational tool that enables individuals with an interest in helping others to function as supervised medical assistants in the clinic.
- a. Responsibilities. Red Cross Volunteers are responsible for scheduling their time in the clinic with clinic staff, accepting supervision, and carrying out activities mutually agreed upon by themselves and the clinic. These duties must fall within the scope of duties for which Red Cross training has prepared the volunteer. Duties may include:



patient transport via gurney or wheelchair within the clinic; assessing and properly recording temperature, respiratory rate, heart rate, and blood pressure; acting as a chaperone during exams or treatment; assisting in specialty areas, i.e., laboratory (with appropriate additional training and supervision); answering telephones, filing and other clerical duties; cleaning and wrapping instruments.

- b. Supervision. Supervision of Red Cross volunteers is the responsibility of the Clinic Administrator and may be delegated.
- c. Orientation. Each volunteer must have an initial orientation to the clinic documented. Orientation shall include at least the following topics:
  - (1) Fire Safety,
  - (2) Emergency procedures (bomb threats, mass casualty, power outages, hurricanes/tornadoes),
  - (3) Universal precautions and infection control,
  - (4) Proper handling of telephone emergency calls,
  - (5) Phone etiquette, paging, proper message taking,
  - (6) Patient Bill of Rights and Responsibilities, to include confidentiality, and chaperone duties in accordance with Chapter 2-J-3-b of this Manual.



## CHAPTER 2.

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## CHAPTER 2. HEALTH CARE AND FACILITIES

### Section A - Health Care for Active Duty Personnel.

#### 1. Care at Uniformed Services Medical Treatment Facilities.

- a. Authority for Health Care. Title 10 USC, 1074(a) provides that under joint regulations to be prescribed by the Secretary of Defense and the Secretary of Transportation, a member of a uniformed service who is on active duty is entitled to health care in any facility of any uniformed service. Members of the reserve components who are on active duty (including active duty for training) are entitled to the same health care in any facility of the uniformed services as that provided for active duty members of the regular services.
- b. Use of Own Service Medical Treatment Facilities. Under ordinary circumstances, members shall receive health care at the Uniformed Services Medical Treatment Facility (USMTF) which serves the organization to which the member is assigned. However, Commanding Officers may request assignment to another USMTF through the cognizant MLC. Members away from their duty station or on duty where there is no USMTF of their own service may receive care at the nearest USMTF.
- c. Use of Other Services Medical Treatment Facilities and/or Civilian Facilities. The closest USMTF having the appropriate capabilities shall be used for non-emergency health care. Health care in civilian medical facilities for non-emergent conditions is not authorized without prior approval of MLC (k). All health care received at other than a CG Clinic shall be recorded in the Coast Guard health record.
- d. Definitions.
  - (1) Uniformed Services are the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration.
  - (2) Active Duty means full-time duty in a Uniformed Service of the United States. It includes: duty on the active list; full-time training duty; annual training duty; and attendance, while in the service, at a school designated as a service school by law or by the Secretary of the Uniformed Service concerned.
  - (3) Health Care means outpatient and inpatient professional care and treatment, nursing care, diagnostic tests and procedures, physical examinations, immunizations, prophylactic treatment, medicines, biologicals, other similar medical services, and ambulance service. Prostheses, hearing aids, spectacles, orthopedic footwear, and similar adjuncts to health care may be furnished only where such adjuncts are medically indicated.
- e. Application for Care. Members of the Coast Guard on active duty may be provided health care at a USMTF when requested by appropriate Coast Guard authority, a



Public Health Service medical officer detailed to the Coast Guard, or by application of the member by presenting an Armed Forces Identification Card (DD-2-CG).

- f. Subsistence Charges. All active duty members of the uniformed services are required to pay subsistence in a USMTF at a rate prescribed by the Department of Defense.
- g. Loss of Entitlement. A member of the Coast Guard who is separated from active duty, for any reason other than retirement, is not eligible for health care at a USMTF by reason of that previous service unless otherwise noted on the Certificate of Release or Discharge from Active Duty form DD-214.

2. Emergency Care at Other Than CG or DOD Facilities.

- a. Definition of Emergency Condition.
  - (1) An emergency medical condition exists when the patient's condition is such that, in a medical officer's opinion, failure to provide treatment or hospitalization would result in undue suffering or endanger life or limb.
  - (2) In an emergency, the patient's safety and welfare, as well as that of the personnel around the patient, must be protected. When a USMTF cannot render immediate care, other local medical facilities, Federal or civilian, may be used. The decision to admit the patient to any of these facilities shall be made by the command with regard for only the health and welfare of the patient and the other personnel of the command.
- b. Eligibility for Emergency Treatment. The following members of the Coast Guard are eligible for emergency medical treatment:
  - (1) active duty personnel of the regular Coast Guard;
  - (2) reserve personnel on extended active duty or temporary active duty (ASWAC); and
  - (3) reserve personnel who become ill, injured, or contract a disease in line of duty while on active duty for training or inactive duty for training, including authorized travel to or from such duty. [see Reserve Policy Manual, COMDTINST M1001.28 (series)]
- c. Responsibilities.
  - (1) Patient.
    - (a) The patient is responsible for notifying the civilian physician or dentist that he or she is in the:
      - 1 Regular Coast Guard;
      - 2 Coast Guard Reserve on active duty or active duty for training; or



- 3 Coast Guard Reserve in an inactive duty training drill or appropriate duty status.
- (b) It is also the responsibility of the patient or someone acting in the patient's behalf to request that the physician or dentist notify the member's command or the closest Coast Guard organization that he or she is undergoing emergency treatment at a civilian medical facility.
  - (c) The patient shall provide to appropriate authority all information needed to verify the course of treatment received and authorize release of all records associated with the episode of care.
- (2) Commanding Officer. When notified that a member of the Coast Guard is hospitalized, transferred to another facility, or discharged from inpatient status, the commanding officer shall notify MLC (p) and (k) via message in accordance with MLC directives.
- (3) Commander, Maintenance and Logistics Command. When notified that a member of the Coast Guard is hospitalized, MLC (k) shall:
- (a) Be responsible for authorizing additional inpatient care at a civilian medical facility prior to transferring the patient to a USMTF. It is imperative, in the interest of good management, that the patient be transferred as soon as medically feasible. However, nothing in the above should be construed as precluding the necessary care for the patient concerned. MLC (k) shall notify the member's unit of any authorization action.
  - (b) Assist in ascertaining all necessary background information about the case, when the patient can be moved, and the location of the nearest CGMTF or USMTF which can accept the case. Patients shall be transferred in accordance with the provisions of Medical Regulating to and Within the Continental United States, COMDTINST M6320.8 (series).
- (4) Commanding Officers of Reserve Units.
- (a) A Reservist needing emergency treatment while performing inactive duty training shall be taken to a USMTF. If the nature of the case is so emergent as to preclude such transportation, a civilian medical facility may be used. If outpatient follow-up treatment is required, (i.e., office visits, tests, etc.) such treatment must be preauthorized by MLC (k) after issuance of a Notice of Eligibility by Commander, Integrated Support Command (FOT).
  - (b) The commanding officer of the reserve unit shall comply with Chapter 11 of the Reserve Policy Manual, COMDTINST M1001.28 (series) in notifying the commander, MLC and ISC (FOT) when a Reservist



engaged in inactive duty training is admitted to a civilian hospital or USMTF, and subsequent follow-up.

- (5) Government Responsibility. Non-adherence to these notification directives cannot limit the Government's liability to pay bills for emergency medical and dental treatment provided to authorized Coast Guard beneficiaries. However, if prior approval is not obtained for NON-EMERGENT treatment in nonfederal facilities, the member receiving the care will be liable for payment.
  - d. Elective Surgery or Medical Treatment. Elective surgery or medical treatment is only authorized in USMTFs.
  - e. Emergency Care Outside the Continental United States. Coast Guard active duty personnel outside the continental limits of the United States are entitled to health care at USMTFs, where available. If such facilities are not available, emergency health care may be obtained at Coast Guard expense, without prior authorization.
  - f. Absentees or Deserters. Charges incurred by Coast Guard personnel for civilian health care when absent without authority or in desertion are the sole responsibility of the individual. However, charges for civilian health care after actual or constructive return of the individual to Coast Guard or military control may be paid from Coast Guard funds. Refer questions on payment of health care in regards to constructive return to MLC (k).
3. Dental Care and Treatment.
- a. Extent of Dental Services.
    - (1) Active duty Coast Guard personnel are entitled to emergency, routine, and accessory dental treatment at all USMTFs. Dental care from contract dentists is authorized only as prescribed in Chapter 11 of this Manual.
    - (2) Reserve Coast Guard personnel ordered to active duty with their consent for less than thirty days are eligible for emergency dental treatment only, and are also subject to the following modifications;
      - (a) Reserve personnel are responsible for all dental diseases and conditions in existence prior to the initiation of or call to active duty. They must be in a class 1 or 2 dental status. (see section 4-C-3.c.)
      - (b) Reserve personnel shall not be eligible for routine or accessory dental treatment which cannot be completed prior to termination of or release from active duty status.
      - (c) Reserve personnel are responsible for maintaining their dental fitness for duty while on inactive status or during periods of active duty less than 30 days.



- (3) Coast Guard Reserve personnel ordered to active duty for 30 days or more, are eligible for emergency, routine, and accessory dental treatment at all USMTFs, and are also subject to the modifications listed above. Reservists with active duty orders for 30 days or more are encouraged to obtain a dental exam as part of their check-in process at their newly assigned unit.

b. Definitions of Types of Dental Treatment.

- (1) Emergency Dental Treatment. Emergency dental treatment includes those procedures directed toward the immediate relief of pain, the removal of oral infection which endangers the health of the patient, and repair of prosthetic appliances where the lack of such repair would cause the patient physical suffering.
- (2) Routine Dental Treatment. Routine dental treatment includes the following: examinations, radiographs, diagnosis and treatment planning, amalgam fillings, synthetic fillings, prophylaxis, extraction, treatment of root canals, treatment for allaying pain, treatment of oral pathological conditions, periodontal conditions, other infections and related conditions detrimental to the patient's health, and repairs and adjustment of dentures and prosthetic appliances.
- (3) Accessory Dental Treatment. Accessory dental treatment includes prosthetic replacement of missing teeth in cases where insufficient occlusal surfaces prevent proper mastication and where missing anterior teeth prevent correct phonation.
- (4) Implants.
  - (a) Implant placement by Coast Guard dental officers (DOs) shall be performed only by:
    - 1 those DOs specifically privileged to do so by DOD facilities, or
    - 2 those DOs who have received implant training as part of a formal specialty program.
  - (b) Implant maintenance is the responsibility of all DOs. Each DO shall be familiar with the techniques and armamentarium of implant maintenance, as well as diagnosis of successful and unsuccessful implants.
  - (c) Requests for implants from nonfederal providers for active duty members shall be approved or denied on a case-by-case basis by the cognizant MLC. Factors to be considered include:
    - 1 oral hygiene;
    - 2 treatment alternatives;
    - 3 feasibility and expectations for long-term success;



- 4 length of service and anticipated rotation; and
    - 5 qualifications of the provider(s).
- c. Dental Care of Recruits. Only emergency dental treatment should be provided those recruits who are to be separated from the Service prior to completing recruit training. It is important that recruits in this category do not have teeth extracted in preparation for prosthetic treatment and then be separated from the Service prior to the time prosthetic appliances are provided.
- d. Emergency Dental Treatment in Nonfederal and Non-contract Facilities.
  - (1) If a contract dentist is not available, emergency dental treatment required for the immediate relief of pain or infection may be obtained by active duty Coast Guard personnel from any available dentist. Once the emergency has been alleviated, all follow-up treatment must be from a USMTF or contract dentist unless preauthorized by MLC (k).
  - (2) Process all bills in accordance with Chapter 11 of this Manual.
- e. Criteria To Be Followed When Requesting Orthodontic/Orthognathic Surgical Care.
  - (1) Orthodontic/orthognathic surgical treatment can affect release from active duty, rotation dates, and fitness for duty. Therefore, written authorization to commence all orthodontic/orthognathic surgical treatment (whether elective or not, and whether provided by Federal or nonfederal practitioners) must be requested from Commander (CGPC-epm) for enlisted and (CGPC-opm) for officers via the cognizant MLC (k) prior to its initiation. Command endorsement must include a copy of Administrative Remarks CG-3307 documentation described in article 2-A-3.e.(3)(b) below. Request nonfederal care from appropriate MLC (k) following established guidelines. If authorized by MLC (k), the request will be forwarded to Commander (CGPC-epm or opm).
  - (2) Preexisting conditions are the member's responsibility.
  - (3) Treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the Coast Guard. If the member's condition does not impair job function, the treatment shall be considered elective.
  - (4) Elective care may be obtained, if available, from USMTFs. If obtained from nonfederal providers, payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective. Because complications could lead to subsequent action by the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's command is responsible for Service Record Administrative Remarks CG-3307 documentation detailing:



- (5) The personnel action to be taken by the command regarding the granting of absence.
- (6) That the service member was instructed regarding the provisions contained herein and other applicable directives; and
- (7) That the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard dental record, including (for example) initial evaluation, treatment plan, progress notes, and follow-up care.
- (8) If elective treatment is approved, PDES processing shall be suspended pending the outcome of the elective treatment. Aviation personnel and divers are required to have a waiver request approved by CGPC - opm or epm. In addition, members whose duties preclude regular visits to an orthodontist (e.g., icebreakers crews, isolated LORAN duty etc.) fall under this category.
- (9) If the condition is service-related, the Coast Guard shall be responsible to acquire care sufficient to return the member to fit for full duty status (e.g., that which existed at the time of the member's entry to the service), but not necessarily to ideal conditions not impacting on performance of duties. If treatment is not available at a local MTF, use of a nonfederal provider may be authorized.
- (10) If pain is the only symptom causing the member to be not fit for full duty, then it must be treated. Treatment may include, but is not limited to physical therapy, bite plates to improve occlusion, stress management, and medications. Since orthodontic treatment is of long duration, it is not an appropriate method to relieve acute pain.
- (11) All treatment must be completed, inactivated, or terminated prior to transfer or release from active duty. Personnel who are being transferred or released from active duty, and who request inactivation of orthodontic appliances, shall sign an entry in the SF-603/603-A stating their intention to seek orthodontic therapy at their own expense.

4. Consent to and Refusal of Treatment.

- a. Regulatory Restrictions. Coast Guard Regulations, COMDTINST M5000.3 (series), state in Section 8-2-1 that:
  - (1) "Persons in the Coast Guard shall not refuse to submit to necessary and proper medical or dental treatment to render themselves fit for duty, or refuse to submit to a necessary and proper operation not endangering life."
  - (2) "Persons in the Coast Guard shall permit such action to be taken to immunize them against disease as is prescribed by competent authority."
- b. Policy Concerning Refusal of Treatment.
  - (1) Policy.



- (a) It is the Commandant's policy that compulsion is not permissible at any time to require Coast Guard personnel to submit to various types of medical or dental treatment, diagnostic procedures, or examinations.
  - (b) Surgery will not be performed on persons over their protest if they are mentally competent.
  - (c) Individuals who refuse to submit to measures considered by competent medical or dental officers to be necessary to render them fit for duty, may be processed for separation from the Coast Guard in accordance with applicable regulations. Individuals may be subjected to disciplinary action for refusal of necessary treatment or surgery if the refusal is determined to be unreasonable. Refusal of medical care by vegetative or comatose individuals in accordance with a **Living Will** shall not be considered unreasonable.
- (2) Non-Emergent Operations on Minors. A minor who enlists or otherwise enters active duty with parental or guardian consent is considered emancipated during the term of enlistment. There is, therefore, no legal requirement that the consent of any person, other than the minor, be obtained prior to instituting surgical procedures.
  - (3) Refusal of Emergency or Lifesaving Treatment or Emergency Diagnostic Procedures. The refusal of recommended emergency or lifesaving treatment or emergency diagnostic procedure required to prevent increased level of impairment or threat to life is ordinarily determined to be unreasonable. However, refusal of medical care by vegetative or comatose patients under the authorization of a **Living Will** is not considered unreasonable. A medical board shall be convened in accordance with the Physical Disability Evaluation System, COMDTINST M1850.2 (series) for unreasonable refusal of emergency or lifesaving treatment or emergency diagnostic procedures.
  - (4) Refusal of Non-Emergent Treatment. If a member of the Coast Guard refuses non-emergent medical, surgical, dental, or diagnostic procedures that are required to maintain a fit for full duty status, a determination of reasonable basis for this refusal is required. A medical board shall be convened in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).
- c. Advance Directives (**Living Wills**).
- (1) Federal law enacted in 1993 requires hospitals to ask about advance directives at the time of admission and provide patients with information to create advance directives. Advance directives, commonly known as **living wills**, express a person's wishes regarding certain aspects of treatment and care, including but not restricted to CPR, mechanical life support measures, etc., which may arise in the course of hospitalization.



- (2) Coast Guard health care facilities are not required to provide such information under the law. Clinics may elect to provide standardized information to patients on request. Information given out shall conform to the implementing laws of the state in which the clinic is located. Clinics providing such information shall notify patients of its availability either by posted notice or via patient handout materials.
- (3) Clinic staff members usually do not have the required training and experience to advise patients on the legal issues concerning creation of advance directives. Patients shall be referred to the appropriate source of legal support, e.g., command or district legal officers.
- (4) Clinic staff members, where allowed by state law, may serve as witnesses to advance directive signatures.
- (5) Advance directive documents shall be held by the member and/or the member's next of kin. Advance directive documents shall not be filed in the member's health record since health records are not universally available 24 hours a day, seven days a week, for reference by a treating hospital.

5. Elective Surgery for Pre-Existing Defects.

- a. General. In many medical/dental procedures undertaken to correct defects that existed prior to entrance (EPTE) into the Service, the likelihood of return to full duty is questionable. In addition, such cases have often resulted in long periods of convalescence with subsequent periods of limited duty, outpatient care, and observation which render the Government liable for benefits by reason of aggravation of these defects.
- b. Criteria. The following conditions must be met before attempting surgical correction of an EPTE defect.
  - (1) It interferes with the member's ability to perform duty.
  - (2) The procedure being considered is an accepted one, carries a minimal risk to life, and is not likely to result in complications.
  - (3) There should be a 90 percent chance that the procedure will correct the defect and restore the member to full duty within a reasonable time (three months) without residual disability. If the defect does not meet the above conditions and the member is, in fact, unfit to perform the duties of grade or rate, action shall be taken to separate the member from the Service.
- c. Discussion. Whether elective medical/dental care should be undertaken in any particular case is a command decision which should be decided using the above guidelines. In questionable cases, the member may be referred to a medical board for final decision prior to undertaking elective treatment for an EPTE defect.



6. Elective Health Care.

- a. Medical/Dental treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the Coast Guard. If the member's condition does not interfere with their ability to perform duty, the treatment shall be considered elective.
  - (1) Elective care may be obtained, if available, from USMTF's.
  - (2) If obtained from nonfederal providers, payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.
  - (3) Because complications could lead to subsequent action by the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's health record must contain a SF-600 entry detailing:
    - (a) the personnel action to be taken by the command regarding the granting of absence;
    - (b) that the service member was counseled regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local Coast Guard primary care facility, or if there is no near by Coast Guard primary care facility, then the cognizant MLC (k) via phone. SF-600 will be faxed to the cognizant MLC (k) for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.
    - (c) that the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard health record, including initial evaluation, treatment plan, progress notes, and follow-up care.
  - (4) If elective treatment is provided, it shall not affect the member's present or future fitness for duty. For example, radial keratotomy is disqualifying for divers and aviators.

7. Other Health Insurance (OHI)

- a. General. In some situations a member may desire to utilize their spouses' health insurance (OHI) to obtain health care outside of the Military Health Care System. Whether elective health care or all other areas of health care, this decision has an impact on the command and possibly on a member's access to the Physical Disability Evaluation System (PDES).
- b. Criteria. The following conditions must be met before utilizing a spouse's health insurance or OHI,



- (1) **ALL** payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.
- (2) Because complications could lead to a loss of access to the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's Coast Guard health record must contain a SF-600 entry detailing:
  - (a) the personnel action to be taken by the command regarding the granting of absence;
  - (b) that the service member was instructed regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local Coast Guard primary care facility, or if there is no near by Coast Guard primary care facility, then the cognizant MLC (k) via phone. SF-600 will be faxed to the cognizant MLC (k) for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.
  - (c) that the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard health record, including initial evaluation, treatment plan, progress notes, and follow-up care.

8. Procedures for Obtaining Non-Emergent Health Care from Nonfederal Sources.

(Guidance reflecting current TRICARE procedures for obtaining Non-Emergent Health Care will be promulgated in future changes to this Manual).

- a. Nonfederal sources for active duty care are intended to supplement and not substitute for care that is available through the federal system. USMTF's or DVA facilities, if located within a 40 mile radius of the member's unit (except a 30 mile radius for maternity care), shall be used first for non-emergent, non-elective health care before nonfederal sources are used. Each case must be evaluated for:
  - (1) appropriateness of care;
  - (2) urgency of treatment;
  - (3) time and cost factors associated with obtaining such care from a USMTF;
  - (4) the member's anticipated length of stay at the given station; and,
  - (5) operational need of the unit for the member.
- b. Before active duty personnel are treated in a nonfederal medical facility for non-emergent conditions, prior approval must be obtained. Non-elective conditions are those which, without repair or treatment, would render the member unfit for duty.
- c. MLC (k) may approve requests for nonfederal health care (both medical and dental) and may delegate, in writing, limited authority to qualified clinic administrators.



- d. Requests for nonfederal health care beyond a clinic administrator's authority will be submitted by following the cognizant MLC(k) policy. Telephone authorization will not be provided without a hard copy of the request. As a minimum, the following information must be provided, as applicable:
- (1) name, grade/rate, social security number;
  - (2) anticipated rotation date and expiration of enlistment;
  - (3) whether care will be completed before transfer or separation;
  - (4) diagnosis reported by International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code number and a brief explanation;
  - (5) history of patient's condition;
  - (6) total amount of local/MLC approved nonfederal expenditures to date for this condition;
  - (7) the necessity of treatment to maintain fitness to perform duty;
  - (8) treatment plan: length, type of therapy/treatment, and estimated cost (Cost estimates must include total scope of care not just primary provider or hospital costs.);
  - (9) name of facility where treatment will be done;
  - (10) attending physician's or dentist's prognosis with and without treatment, including likelihood of medical board action;
  - (11) treatment plan and justification, radiographs and copy of dental records for all dental requests (Study models will be submitted for all cases requiring crown and bridge work and partial dentures;
  - (12) name of nearest USMTF capable of providing care:
    - (a) distance to facility (miles);
    - (b) earliest appointment available (not available is unacceptable);
    - (c) travel/per diem cost;
    - (d) estimated total lost time; and
    - (e) other factors for consideration, i.e., travel time, road conditions, operational impact, etc; and
  - (13) indicate date of original submission and reason for resubmission, if previous requests were submitted for this procedure.
- e. If approval is granted, MLC (k) will provide the requester with an authorization number. This authorization number must be noted on all bills submitted. Bills will be submitted to MLC (k). If approval is denied, MLC(k) will outline the appropriate appeals process to follow in their denial transmittal.



- f. When personnel are transferred prior to completing the approved care, the request is canceled. Personnel are required to submit another request after reporting for their new assignment.
  - g. Amounts authorized shall not be exceeded without further authorization from MLC (k) which requires additional justification.
  - h. Inpatient hospitalization in nonfederal facilities shall be monitored closely by the MLC (k) responsible for the geographical area in which the facility is located. Normally, an inpatient stay will not exceed seven days duration without consideration of movement to a USMTF. Cases suspected to extend past the seven-day limit shall not be placed in a civilian facility, but shall be initially referred to a USMTF.
  - i. If prior approval is not obtained for non-emergent treatment in nonfederal facilities, the member receiving the care will be liable for payment.
  - j. EMERGENCY health care does not require prior approval.
9. Obtaining Vasectomies and Tubal Ligations from Nonfederal Providers.
- a. Preauthorization is required. Submit all request for vasectomies and tubal ligations by nonfederal providers to cognizant MLC(kma) following the guidelines for requesting above. Request must show the provider of care decided on the procedure based upon applicable local and state guidelines.
  - b. Request must contain evidence that the patient has been counseled by a physician and has given informed consent to the procedure.
  - c. The request must contain evidence that the patient has completed a SF-600 entry acknowledging that the Coast Guard will not pay for reversal of this procedure in a non-federal facility.
  - d. The request must contain current information concerning the availability of the requested procedure from federal sources.
  - e. Request for tubal ligation to be performed at the time of delivery should be submitted with the request for nonfederal maternity care.
  - f. Sick leave may be granted for this procedure.
10. Care at Department of Veterans Affairs (DVA) Medical Facilities.
- a. From time-to-time, acute medical, surgical, or psychiatric facilities are required for Coast Guard personnel where transportation to the nearest USMTF will place the individual's health or welfare in jeopardy. To preclude this and other similar situations and to provide the best possible medical care for all active duty members, a



support agreement between the Coast Guard and the Department of Veterans Affairs was completed in 1979 and remains in effect. FIGURE 2-1 is a copy of the medical service agreement.

- b. DVA care must be requested by the member's commanding officer. The agreement is limited to active duty Coast Guard personnel and does not include dependents.
- c. MLC commanders and commanding officers should establish local contact with DVA facilities to determine mission and facility capabilities and patient admission procedures.
- d. Forward all bills received from DVA facilities to the service member's unit for certification prior to forwarding to MLC (k) for payment.
- e. When a USMTF and a DVA facility are collocated, the USMTF shall be used unless it cannot provide the required services.



MEDICAL SERVICE AGREEMENT  
BETWEEN THE  
U. S. COAST GUARD  
DEPARTMENT OF TRANSPORTATION  
AND THE  
VETERANS ADMINISTRATION

This agreement provides for medical services to be furnished the U.S. Coast Guard, Department of Transportation (hereinafter referred to as "CG") by the Veterans Administration (hereinafter referred to as "VA") and establishes the terms and conditions under which the services are to be furnished to active duty personnel.

**I. BACKGROUND.**

In February 1973, arrangements were established whereby CG active duty personnel utilized the VA hospital facilities for medical services. This agreement provides for the continuation of these services.

**II. MEDICAL SERVICES TO BE FURNISHED BY THE VA.**

- A. Hospital care, medical services and emergency dental treatment may be provided to the extent that such care, services, or treatment are available at the VA medical facility from which requested.
- B. To preclude the possibility of denying or delaying the care and treatment of an eligible veteran, VA medical services will be furnished only to the extent that there will be no reduction in the service to the veteran.

**III. REFERRAL PROCEDURES.**

VA medical services will be provided CG active duty personnel upon receipt of an authorization document from the responsible official at the CG facility. The authorization document will include the billing address for services to be rendered. Telephone authorizations will be accepted in emergencies pending receipt of a written authorization.

**IV. REIMBURSEMENT.**

- A. The CG will reimburse the VA for the services performed at the current appropriate rates periodically approved by the Office of Management and Budget (OMB), except that if a CG beneficiary requires transfer to a non-VA facility, reimbursement shall be at the actual rates charged.
- B. The VA medical center providing the medical services will prepare Standard Form 1081, Voucher and Schedule of Withdrawals and Credits, covering the services. The executed form will be submitted to the CG at the address shown on the authorization request.



FIGURE 2-A-1 con't

V. TRANSPORTATION.

The CG will provide all necessary transportation and medical attendants, when applicable, for personnel scheduled for VA medical treatment. Travel costs to and from the VA medical facility will not be paid by the VA.

VI. LIABILITY.

Protection of the individuals furnishing services covered by this agreement will be that which is provided under 28 USC 1346(b), and by 38 USC 4116.

VII. GENERAL PROVISIONS.

A. Amendments or Cancellations:

This agreement or any of its specific provisions may be revised or amended only by the signature approval of the parties signatory to the agreement or by their respective official successors. Cancellation may be made upon 30 days written notice of either party, or their successors, to the other.

B. Effective Date:

This agreement, amendments to or cancellation thereof, shall become effective upon the date when the Chief, Office of Health Services, CG, and the Director, Supply Service, Department of Medicine and Surgery, VA, both have signed acceptance thereof.

C. Authority:

Authority for this agreement is the Economy Act of June 30, 1932, as amended (31 USC 686).

D. Previous Agreements:

This agreement supersedes previous medical service support arrangements.

ACCEPTED:

VETERANS ADMINISTRATION

ACCEPTED:

DEPARTMENT OF TRANSPORTATION  
U.S. COAST GUARD

By:

Clyde C. Cook  
CLYDE C. COOK  
Director, Supply Service

By:

Harry Allen  
HARRY ALLEN  
Rear Admiral, U. S. Public Health Service  
Chief, Office of Health Services  
U. S. Coast Guard

Date:

Sept 24, 1979

Date:



## Section B - Health Care for Reserve Personnel.

### 1. Care at Uniformed Services Medical Treatment Facilities.

- a. Authority for Reserve Personnel. Section 2-A of this Manual contains the authority for medical care. Information concerning entitlement to various benefits is contained in Chapter 11 of the Reserve Policy Manual, COMDTINST M1001.28(series). Information concerning eligibility for benefits from the Department of Veterans Affairs is included therein.
- b. Application for Care. A member of the Coast Guard Reserve may be admitted to USMTFs upon written authorization from an appropriate Coast Guard authority (e.g., Commanding Officer's letter, Notice of Eligibility, or appropriately endorsed orders).
- c. Definitions. The following definitions apply throughout this section:
  - (1) Active duty means full-time duty in a Uniformed Service of the United States. It includes duty on the active list, full-time training duty, annual training duty and attendance, while in the service, at a school designated as a service school by law or by the Secretary of the Uniformed Service concerned.
  - (2) Active Duty for Training is defined as full-time duty in a uniformed service of the United States for training purposes.
  - (3) Inactive Duty Training.
    - (a) Duty prescribed for reservists by the Secretary concerned under 37 USC 206 or any other provision of law.
    - (b) Special additional duties authorized for reservists by an authority designated by the Secretary concerned and performed by them on voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned.
  - (4) Disability. A temporary or permanent physical impairment resulting in an inability to perform full military duties or normal civilian pursuits.
  - (5) Employed. Reservists are employed on duty during the actual performance of duty, while engaged in authorized travel to or from active duty for training, and while on authorized leave or liberty.
  - (6) Line of Duty. An injury, illness, or disease shall be deemed to have been incurred in line of duty, if a reservist at the time of debilitating incident is performing active duty or active duty for training, or is on authorized leave or liberty, provided the disability is not the result of misconduct.
- d. Injury Incurred in Line of Duty. A member of the Coast Guard Reserve who is ordered to active duty or to active duty for training, or to perform inactive duty training, for any period of time, and is disabled in line of duty from injury while so



employed is entitled to the same hospital benefits as provided by law or required in the case of a member of the regular Coast Guard. For the purpose of these benefits, a member who is not in a pay status is treated as though receiving the pay and allowances to which entitled if serving on active duty.

- e. Disease Incurred in Line of Duty While on Active Duty. A member of the Coast Guard Reserve who is ordered to active duty for training for a period of more than 30 days, and is disabled while so employed, is entitled to the hospital benefits as are provided by law or regulation in the case of a member of the regular Coast Guard. An exception is that a member of the Coast Guard Reserve ordered to perform involuntary active duty for training under the provision of 10 USC 270 is only eligible for the limited medical benefits described below, following termination of the training duty period.
- f. Illness or Disease Contracted in Line of Duty in Peacetime. A member of the Coast Guard Reserve who, in time of peace, becomes ill or contracts a disease in line of duty while on active duty for training or performing inactive duty training is entitled to receive medical, hospital, and other treatment appropriate for that illness or disease. The treatment shall be continued until the disability resulting from the illness or disease cannot be materially improved by further treatment. Such a member is also entitled to necessary transportation and subsistence incident to treatment and return home upon discharge from treatment. The treatment may not extend beyond ten weeks after the member is released from active duty, except:
  - (1) upon an approved recommendation of a medical board or
  - (2) upon authorization of the MLC (k), based on a physician's certification that the problem is a continuation of that for which the member was initially treated, and that benefit will result from further treatment. Refer to Section 11-B-3 of the Reserve Administration Policy Manual, COMDTINST M1001.28(series), for specific instructions regarding the extension of medical treatment beyond 10 weeks for those who are receiving treatment under a Notice of Eligibility (NOE).
- g. Injury or Disease En Route to or from Active Duty. A member of the Coast Guard Reserve is authorized medical care for an injury or disease incurred while en route to or from active duty, active duty for training, or inactive duty for training.
- h. Injury or Disease Not in Line of Duty. A member of the Coast Guard Reserve is not entitled to medical care for an injury or disease not incurred in the line of duty.
- i. Pregnancy. Pregnancy in the Coast Guard, COMDTINST 1900.9, contains guidance regarding pregnancy and reserve members. Use of reserve servicewomen who are pregnant for ASWAC assignment is not encouraged. Reserve servicewomen may accept Special Active Duty for Training (SADT) with the understanding that duty must be completed by the 24th week of gestation.



2. Emergency Care at Other Than CG or DOD Facilities. Section 2-A-2 contains the requirements for treating reserves in emergency situations.
3. Non-Emergent Care at Other Than CG or DOD Facilities. Any non-emergent, nonfederal care must be authorized in advance by MLC (k) through contract, blanket purchase agreement or pre-authorization.



## Section C - Health Care for Retired Personnel.

1. Care at Uniformed Services Medical Treatment Facilities. As set forth in 10 USC, 1074(b), retired members of the uniformed services, as specified in that Act, are entitled to required medical and dental care and adjuncts thereto to the same extent as provided for active duty members in medical facilities of the uniformed services. However, access to care is subject to mission requirements, the availability of space and facilities, and the capabilities of the medical staff as determined by the cognizant medical authority in charge. Patients enrolled in TRICARE Prime Options are not eligible for non-emergent care in Coast Guard clinics. These patients shall be referred to their TRICARE primary care manager (PCM). The PCM is responsible for appropriate care and referral of such patients.
2. Care Under the TRICARE Extra and Standard Options (formerly CHAMPUS). Subject to the cost sharing provisions set forth in 10 USC, 1086, retired members who are not qualified for benefits under Title I of the Social Security Amendments of 1965 (Medicare) are entitled to receive inpatient and outpatient care from civilian sources.
3. Care at Veterans Administration Medical Facilities.
  - a. Eligibility for DVA Hospitalization. Coast Guard military personnel are eligible for hospitalization in DVA facilities after separation from active duty or while in retirement under one of the following circumstances:
    - (1) For injuries or diseases incurred or aggravated while on active duty during any war, the Korean conflict period (27 June 1950 through 31 January 1955) or the Vietnam conflict period (5 August 1964 through 7 March 1975).
    - (2) For service-connected or nonservice-connected disabilities, if receiving disability compensation from the DVA, or if entitled to receive disability compensation from the DVA, but has elected to receive retirement pay from the Coast Guard instead of the compensation from the DVA.
  - b. Medical Care Benefits. Eligible veterans may receive hospitalization, outpatient medical care, outpatient dental care, prosthetic appliances, etc., from the VA.



## Section D - Health Care for Dependents.

### 1. Care at Uniformed Services Medical Treatment Facilities.

- a. Authority for Health Care. Title 10 USC, 1076 provides basic authority for medical and dental care for:
  - (1) dependents of active duty members and dependents of members who died serving on active duty; and
  - (2) dependents of retired members and the dependents of members who died while in a retired status.
- b. Availability of Care.
  - (1) Medical and dental care for dependents in uniformed services medical treatment facilities is subject to the availability of space and facilities and the capabilities of the medical and dental staff. With the approval of the commanding officer, the senior medical officer and senior dental officer are responsible for determining the availability of space and capability of the medical and dental staffs. These determinations are conclusive. Patients found enrolled in TRICARE Prime Options are not eligible for non-emergent care in Coast Guard clinics. These patients shall be referred to their TRICARE primary care manager (PCM). The PCM is responsible for appropriate care and referral of such patients.
  - (2) Dependents entitled to medical and dental care under this section shall not be denied equal opportunity for that care because the facility concerned is that of a uniformed service other than that of the sponsor.
  - (3) Types of Care Authorized. Subject to the provisions set forth in 10 USC, 1079 and 1086, dependents who are not qualified for benefits under Title 1 of the Social Security amendments of 1965 (Medicare) are entitled to receive inpatient and outpatient care from civilian sources. Refer to your cognizant MLC (k) for details and instructions.

2. Care Under Coast Guard Civilian Contracts. Under certain circumstances, dependents are entitled to medical and dental care provided through Coast Guard civilian contracts. See Chapter 11 for guidance.
3. Rights of Minors to Health Care Services. Where not in conflict with applicable Federal law or regulation, unit commanding officers shall follow State law defining the rights of minors to health care services and counseling in contraception, sexually transmitted disease prevention and treatment, and pregnancy. Any protection with regard to confidentiality of care or records afforded by applicable law or regulation will be extended to minors seeking care or counseling for the above mentioned services or conditions in Coast Guard facilities.



## Section E - Care for Preadoptive Children and Wards of the Court.

### 1. General.

- a. A child placed in a sponsors home as part of a pre-adoption procedure, or by court-ordered guardianship, is not eligible for care under the Uniformed Services Health Benefits Program unless specific authority has been granted. Such authority may come from the final adoption decree, a court-ordered legal custody determination (for a period of at least 12 consecutive months), or through a Secretary's Designation authorization for limited health care in a USMTF.
- b. Eligibility for TRICARE benefits, the Uniformed Services Family Health Benefits Plan (USFHBP), or the Uniformed Services Active Duty Dependents Dental Plan is established upon the issuance of a uniformed services dependent ID card and DEERS enrollment. Authorization for these health care programs, or for direct care (USMTF use), will be reflected on the ID card and through DEERS.
- c. Prospective dependents must meet the following eligibility rules: be unmarried; have not attained the age of 21 (or 23 if a full-time student); be dependent on the sponsor for over one-half of their support; or be incapable of self-support due to mental or physical incapacity and were otherwise eligible when incapacity occurred.
- d. If legal custody or placement is for 12 months or more, a uniformed services dependent ID card, DEERS enrollment, and health care eligibility may be authorized. Personnel are encouraged to contact their servicing personnel office for assistance.

### 2. Secretary's Designation. The following procedures apply in situations where a pre-adoptive or court ordered guardianship or placement is for less than 12 consecutive months.

- a. Children under a prospective parent or guardians care may use a USMTF by acquiring authority from the Secretary of the uniformed service to which the USMTF belongs. This authority is normally called a Secretary's Designation. For example, requests for care in a U. S. Navy facility must be authorized by the Secretary of the Navy or their designee. The same holds true for U. S. Army and U. S. Air Force facilities. When seeking care from a Department of Defense MTF, contact that facilities Patient Affairs or Health Benefits Advisor staff for assistance.
- b. In cases involving Coast Guard facilities, authority has been delegated to the Commandant by the Secretary of Transportation to authorize treatment of pre-adoptive children and wards of the court. Letter requests must be forwarded to Commandant (G-WKH) and include the following information:
  - (1) member's name, grade/rate, SSN, and duty assignment or retired status if applicable;
  - (2) address of residence;



- (3) name and age of the proposed adoptive child or court-ordered ward; and
  - (4) a copy of the court order, legal decree, or other applicable instrument issued by a court or adoption agency which indicates the child has been placed in the house for adoption or with the intent to adopt, or the court order granting guardianship of the ward to the service member and any amounts of income to which the ward is entitled.
- c. Upon approval, the respective uniformed service will issue a letter of authority for care in one or more of their USMTFs located in the United States. This letter is the only authority for care (since designees are not DEERS-eligible) and must be presented (or on file) when seeking authorized care. These letters have expiration dates and may require the sponsor to request to reissue.
- d. When there is a need for medical care outside the United States, the sponsor should contact the nearest USMTF requesting humanitarian consideration. The Service Secretaries have limited authority for designation of beneficiaries outside the United States.



## Section F - Health Care for Other Persons.

### 1. Members of the Auxiliary.

- a. Authority for Care of Auxiliary Members. Basic authority for health care for members of the Auxiliary injured while performing Coast Guard duty is contained in 14 USC 832. Section 5.59 of Chapter 1, Title 33, CFR, states: "When any member of the Auxiliary is physically injured or dies as a result of physical injury incurred while performing patrol duty or any other specific duty to which he has been assigned, such member or his beneficiary shall be entitled to the same benefits as are now or as may hereafter be provided for temporary members of the Coast Guard Reserve who suffer physical injury incurred in the line of duty. Members of the Auxiliary who contract sickness or disease while performing patrol duty or any other specific duty to which they have been assigned shall be entitled to the same hospital treatment as is afforded members of the regular Coast Guard." Claims for Auxillary healthcare shall be submitted to:

U. S. Department of Labor  
OWCP Special Claims Branch (District 25)  
800 North Capitol Street, NW, Room 800  
Washington, DC 20211

- b. Compensation Under Federal Employee's Compensation Act (FECA) Program. See the Detail of Civilian Employees, COMDTINST M12300.7 (series).

### 2. Temporary Members of the Reserve.

- a. Composition of the Reserve. The Coast Guard Reserve is a component part of the United States Coast Guard and consists of two classes of reservists: Regular and Temporary. Temporary members of the Reserve may be enrolled for duty under such conditions as the Commandant prescribes, including but not limited to part-time and intermittent active duty with or without pay, and without regard to age. Members of the Auxiliary, officers and members of the crew of any motorboat or yacht placed at the disposal of the Coast Guard, and persons (including government employees without pay other than compensation of their civilian positions) who by reason of their special training and experience are deemed by the Commandant qualified for such duty. The Commandant is authorized to define the powers and duties of temporary reserves, and to confer upon them, appropriate to their qualifications and experience, the same grades and ratings as are provided for regular members of the Reserve.
- b. Authority for Care of Temporary Reservists. Section 760, Title 14, USC, contains authority for health care and/or compensation of temporary reserves under conditions set forth therein.



- c. Care at Coast Guard Expense. 14 USC 760(d) states: "Temporary members of the reserve who incur physical disability or contract sickness or disease, while performing any specific duty to which they have been assigned by competent Coast Guard authority, shall be entitled to the same hospital treatment afforded officers and enlisted men of the Coast Guard."
  - d. Compensation Under Federal Employee Compensation Act (FECA) Program. See Detail of Civilian Employees, COMDTINST M12300.7
- 3. Members of Foreign Military Services.
  - a. General. Members and dependents of foreign services assigned or attached to a Coast Guard unit for duty or training (such as Canadian Exchange Officers) or who are on active duty with a foreign military unit within the United States (such as the crew of a vessel being taken over at the Coast Guard Yard under the Military Assistance Program) are eligible for inpatient health care at DoD MTF's provided by US Code: Title 10, Section 2559. As there are several categories of foreign service members for whom medical care benefits vary, both for themselves and their dependents, if any doubt exists as to eligibility for health care and the authorized sources from which it can be obtained, contact Commandant (G-WKH) for advice.
  - b. Care at Uniformed Services Medical Treatment Facilities. Members of foreign military services and their dependents who are eligible, therefore, shall be provided inpatient health care at DoD MTFs upon request of the member's commanding officer or consular official, or by application of the member or dependent upon presentation of proper identification.
- 4. Federal Employees.
  - a. Benefits Under Federal Employees Compensation Act (FECA) Program. All Federal Employees assigned to Coast Guard vessels, e.g., National Marine Fishery Service (NMFS), Drug Enforcement Agents, etc., are civilian employees of the United States Government, and as such, are entitled to health care and compensation under FECA. See Detail of Civilian Employees, COMDTINST M12300.7 (series).
  - b. Care Aboard Ship and Outside CONUS. Federal Employees may be given medical care while serving with the Coast Guard in a locality where civilian health care is not obtainable, such as on board a Coast Guard vessel or outside the United States. Outpatient and inpatient care may be provided at Navy medical facilities outside CONUS, if reasonably accessible and appropriate nonfederal medical facilities are not available.
- 5. Seamen. Sick and disabled seamen may receive emergency health care aboard Coast Guard vessels.



6. Nonfederally Employed Civilians Aboard Coast Guard Vessels.

- a. Authority for Care. There is no statute which either prohibits or authorizes the Coast Guard to provide health care to civilians while aboard Coast Guard vessels. There is no objection to furnishing emergency health care, but routine care should not be furnished. When these civilians are aboard Coast Guard vessels for relatively lengthy periods, the commanding officer must determine what treatment is to be given.
- b. Responsibility. Commanding officers of vessels deployed for extended periods shall ensure that nonfederally employed civilians who are carried aboard Coast Guard vessels under their cognizance are physically capable of withstanding the trip contemplated and that they are free from medical conditions which could cause an interruption of the vessel's mission. Nonfederally employed civilians must furnish such evidence from a physician at no expense to the Coast Guard or Federal Government.



## Section G - Medical Regulating.

1. Transfer of Patients at Coast Guard Expense.
  - a. Details for the transfer of Coast Guard personnel to, from, or between hospitals and the responsibility for the expenses involved are contained in Chapter 4 of the Personnel Manual, COMDTINST M1000.6 (series).
  - b. Information and requirements for the transfer of patients to, from, or between medical facilities is contained in COMDTINST M6320.8 (series), Medical Regulating to and Within the Continental United States.
2. Travel Via Ambulance of Patients to Obtain Care.
  - a. Active Duty Personnel. The Coast Guard is responsible for providing ambulance service (Government or civilian), for active duty members when medically necessary. Bills related to ambulance service provided to active duty personnel, shall be processed as outlined in Chapter 11 of this Manual.
  - b. Retired and Dependent Personnel. Retired personnel and dependents are not provided ambulance service for initial admission, except that a Government ambulance may be used in an emergency situation as determined by the cognizant medical authority. If an ambulance is ordered by a military hospital, TRICARE Standard can not pay for it; the military hospital must pay. TRICARE Standard cost –shares ambulances only when medically necessary; that is, the patient’s condition does not allow use of regular, private transportation or taxis, “medicabs” or “ambicabs.” Ambulance transportation must be needed for a medical condition that is covered by TRICARE Standard. Should either the provider or patient have additional questions regarding this issue check with the cognizant MLC(k), HBA or TRICARE Service Center.
3. Aeromedical Evacuation of Patients. When the condition of the patient requires aeromedical evacuation, the transfer shall be arranged in accordance with Medical Regulating To and Within The Continental U.S. (Joint Pub), COMDTINST M6320.8 (series). If there is no USMTF in the area, a message prepared in accordance with the above instruction shall be forwarded to MLC (k).



## Section H - Defense Enrollment Eligibility Reporting System (DEERS) in Coast Guard Health Care Facilities.

1. Defense Eligibility Reporting System. This Section provides guidance for Coast Guard health care facilities on the use of the Defense Enrollment Eligibility Reporting System (DEERS) to verify patient eligibility to receive care.
  - a. DEERS was established in 1979 by the Department of Defense to comply with a Congressional mandate. The two initial objectives of DEERS were to collect and provide demographic and sociographic data on the beneficiary population entitled to DOD health benefits, and to reduce the fraud and misuse of those benefits. The original scope of DEERS has since been broadened to include the maintenance and verification of eligibility status for all uniformed services beneficiaries. Worldwide implementation of DEERS and its registration were completed in 1985.
2. Responsibilities.
  - a. Commandant (G-WKH) provides overall functional management of the Coast Guard DEERS program for health services facilities. In this role, Commandant (G-WKH) provides guidance to field activities, represents the Coast Guard to the DEERS Central Systems Program Office (DCSPO), and on the DEERS Central Systems Project Officers Committees.
  - b. Commanders, Maintenance and Logistics Commands (k) shall appoint an MLC DEERS medical project officer and alternate, who shall ensure that facilities in their respective areas participate in and comply with DEERS program requirements.
  - c. Commanding officers of units with health care facilities shall ensure that the Chief of the Health Services Division appoints the following individuals in writing:
    - (1) DEERS Project Officer and alternate who are responsible for the overall management of the DEERS system in the clinic;
    - (2) Site Security Manager (SSM) and alternate who are responsible for system security as outlined in paragraph 3; and
    - (3) individuals authorized to deny care.
3. Security.
  - a. The Site Security Manager (SSM) should be the health services division or unit computer systems administrator. The security manager is responsible for maintaining passwords, authorized user list, etc., and advising the DEERS contractor when changes occur.
  - b. The SSM also requests site identification (site-ID) codes for the clinic. These codes are requested through the MLC DEERS Project Officer to Commandant (G-WKH).



As a rule, there is only one site ID required per clinic. The SSM also ensures information systems security awareness training/briefing is given to new DEERS users prior to allowing them access to DEERS and to all DEERS users annually.

- c. If the clinic DEERS project officer is not the SSM, the security manager must closely coordinate activities with the DEERS project officer. Immediately after appointment, the SSM must telephone the DEERS Security Maintenance Office at (703) 820-4850 to notify that office of the appointment. When making this notification, include the following information:

- (1) Site ID number;
- (2) Rank or grade of SSM;
- (3) Name (last, first, middle initial);
- (4) Social Security Number (SSN);
- (5) Duty location;
- (6) Duty title; and
- (7) Telephone number.
- (8) After telephone notification, submit a letter of appointment and a Request for Data Base Additions, Deletions, or Changes (Figure 2-H-1) to:
- (9) Security Maintenance Office  
DEERS East Coast Center  
1600 North Beauregard St.  
Alexandria, VA 22311

- d. User Password Maintenance.

- (1) The DEERS security system requires a six-character user-ID and a six to eight character password. The user-ID is assigned by DEERS, and is permanent. An initial password is assigned by the DEERS government contractor. The password expires at 30 day intervals. At the end of each 30 day period, the user is required to change the initial password to one of his or her own choosing, so long as it meets the six- to eight-character requirement. Access to the data base is granted by using a unique user-ID, password, and the transaction identifier (TRAN-ID). The TRAN-ID for medical/dental is GIQD.
- (2) To add a new user, submit a Request for Data Base Additions, Deletions, or Changes. Be sure to include the site-ID and SSN of any new personnel.
- (3) To delete a current user, submit a Request for Data Base Additions, Deletions, or Changes requesting the deletion to the DEERS Security Maintenance Office.
- (4) User IDs not used for 60 days are automatically deleted and access is not possible. To regain access, the SSM must reapply for a new user-ID by submitting a new Security Manager Update.



- (5) Authorized users must be kept to the absolute minimum, consistent with job requirements.

#### 4. Performing DEERS Checks.

- a. Whom to check: All beneficiaries of the military health care system are subject to DEERS eligibility verification, with the following exceptions:
  - (1) Coast Guard cadets, officer candidates, and recruits while undergoing training;
  - (2) Active duty personnel receiving dental care at a military facility; and
  - (3) Secretarial Designees, including pre-adoptive children and wards of the Court, ARE NOT ELIGIBLE for care under the TRICARE programs. They are also not enrolled in DEERS. Verification of the eligibility of Secretarial Designees for care in a military facility is accomplished through the individual's actual letter of designation. Refer to Section 2-E for further information.
- b. When to check: Coast Guard health services facilities should verify the eligibility of all beneficiaries prior to providing health care. The following minimum eligibility checks shall be made:
  - (1) 100% of all outpatient medical visits;
  - (2) 25% of all dental visits;
  - (3) 10% of pharmacy visits to fill "in-house" prescriptions;
  - (4) 100% of pharmacy visits with prescriptions written by civilian providers;
  - (5) 100% of all inpatient admissions; and
  - (6) 100% of dental visits when the patient may be eligible for the TRICARE Family Member Dental Program;
  - (7) 100% of retired members at the initial visit to a dental facility, and annually thereafter at the time of treatment.
  - (8) Upon initial presentation by dependents for evaluation or treatment. This check will be valid for 30 days, if the period of eligibility (dates of treatment) requested from DEERS is 30 days.
  - (9) When a non-active duty patient is referred to a civilian provider for supplemental care.
  - (10) When active duty personnel are referred to a civilian provider under the Active Duty Claims Program.
  - (11) When any patient (active duty, retired, dependent, or survivor) is referred to a Military Treatment Facility (MTF) or a Uniformed Services Treatment Facility (USTF).
  - (12) When in doubt verify enrollment and eligibility.



- (13) Coordinated/Managed Care: Verification of eligibility will be conducted according to the policies and procedures of the sponsoring hospital/organization. Coast Guard facilities participating in coordinated/managed care programs are considered, by that participation, to be in compliance with the eligibility verification requirements of the DEERS program for medical patients. Dental patients will still be subject to the above checking requirements until a dental coordinated care program is established.
  - (14) Each clinic is required to perform a published number of checks each month. These requirements are based on the outpatient visits of each clinic from the previous year. Updated annual requirements will be published each January by Commandant Notice.
- c. How to check. DEERS checks for patient registration and eligibility can be done in a number of ways. The following examples are the most common ways to verify eligibility:
- (1) Telephone-Based System. Eligibility checks are done by contacting DEERS direct by telephone. Procedures for performing DEERS checks by telephone are found in Figure 2-H-2.
  - (2) Computer Link Using the Coast Guard Standard Terminal. Procedures for using the Standard Terminal are attached as Figure 2-H-3.
  - (3) DEERS-owned Computer and Software (On-Line) System. Procedures for using DEERS-owned equipment are contained in DOD DEERS Eligibility Inquiry/Nonavailability Statement Users Guide [Pub # UG 0100EL (series)].
  - (4) Use of PERSRU/Admin RAPIDS Terminals. Personnel in health care facilities are discouraged from performing DEERS checks using the RAPIDS terminal that may be available in their unit's Administration Office or PERSRU. Using this resource places an unnecessary burden on the PERSRU/Admin personnel, and using these terminals does not indicate that the required medical checks are being accomplished.
- d. How to request site-ID, data base access, or equipment.
- (1) Site ID.
    - (a) Site ID numbers are assigned to a facility by the DOD DEERS Office. These numbers are used to identify the origin of activity in the DEERS system, and to generate reports of system activity. Site IDs are a mandatory part of the initial request to access DEERS. The request form is attached as Figure 2-H-4. Site IDs are permanent; they need not be renewed.
    - (b) Health Care facilities requesting an initial Site ID, or changing the status of their existing ID shall complete Section I of Figure 2-H-4 and forward, via MLC (k), for further endorsement to:



- (c) Commandant (G-WKH-3)  
U. S. Coast Guard  
2100 Second St., SW.  
Washington, DC 20593-0001  
ATTN: DEERS MEDICAL PROJECT OFFICER  
Telephone: (202) 267-0835

(2) Data Base Access.

- (a) Authorization for individual access to DEERS is done by written request from the clinic/unit Site Security Manager to the DEERS Security Maintenance Office using the "Request for Data Base Additions, Deletions, or Changes" form.
- (b) Clinic personnel who should be considered for access to the DEERS Data Base include those working in medical/ dental records, appointments, pharmacy, patient affairs, and the health benefits advisor.
- (c) Information available from the DEERS data base is subject to the provisions of the Privacy Act.

(3) Equipment Requests or Changes.

- (a) Telephone Access. Requests for access to DEERS via telephone is the simplest and most user friendly means. This method is recommended for facilities making fewer than 20 checks per day. Requests for initial facility and personnel access is done by completing Figures 2-H-1 and 2-H-4 and forwarding them to DEERS security via the MLC and Commandant (G-WKH).
- (b) Computer link using the Coast Guard Standard Terminal. Use of the Standard Terminal, with the proper software emulation package installed, allows facilities with a greater number of required checks to perform those checks without making repeated telephone calls. Equipment required includes a Standard Terminal workstation, Bell 212A compatible modem, appropriate emulation software (VT 100), and an outside commercial/FTS touch-tone telephone line. Facility requests for access using this equipment is done by completing Figure 2-H-4 with an attached statement that the facility has the appropriate hardware and software as listed above. The facility must also state that it will be responsible for any telephone charges incurred using this means of access. Figure 2-H-5 lists complete equipment requirements.
- (c) DEERS-owned computer hardware and software system. This **top of the line** system features a direct, on-line, computerized link with the DEERS data base. The minimum justification for requesting this equipment is performing more than 100 DEERS checks per day. A limited number of



Coast Guard health care facilities have this equipment. For further information on this system, contact the Medical Project Officer at Commandant (G-WKH-1).

5. Reports. No reports from field units documenting DEERS activity are required. Two commonly generated reports concerning DEERS activity are described below:
  - a. Monthly Statistical Reports. Upon receipt from DEERS, Commandant (G-WKH) will forward the Monthly Statistical Reports to each MLC (k). These reports list DEERS activity for each clinic during the preceding month. Clinics may also use the on-line statistical report screen to monitor its activity.
  - b. Field Representative Visit Report. These report the findings of each training visit by the DEERS Field Representative to a clinic. These reports reflect the compliance of the facility to DEERS requirements, and whether or not further training for facility personnel is needed. Copies are provided to each MLC (k) and Commandant (G-WKH).
6. Eligibility/Enrollment Questions, Fraud and Abuse.
  - a. Eligibility/Enrollment Questions: Beneficiaries of the military health care system, including active duty and retired personnel, their dependents, and survivors must provide positive proof of eligibility before being provided health care. Eligibility is determined by (a) presenting a valid ID Card and (b) verifying enrollment and eligibility in DEERS.
    - (1) If an individual presents an ID card that is no longer valid (expired), the individual should be refused care and the ID card confiscated.
    - (2) If the individual has a valid ID card, but is not enrolled in DEERS, they should be refused routine care, and referred to their sponsor and/or service ID card activity to be enrolled in DEERS. Following enrollment into DEERS, the patient may prove temporary eligibility (pending their enrollment showing up in the DEERS computer) by presenting a **certified** copy of Application for Uniformed Services Identification Card DD Form 1172 from the ID card activity. Upon presenting of this DEERS enrollment verification, the individual should be considered as fully eligible, and treatment provided.
  - b. Fraud and Abuse: If, in the process of verifying eligibility through DEERS, clinic personnel have reason to believe the person requesting care is doing so even though that person is no longer eligible (e.g. a divorced spouse with a valid ID card, but DEERS shows **NOT ELIGIBLE**), care should be refused, and the details of the situation should be reported to the appropriate personnel activity and investigation office. Clinic personnel reporting suspected fraud should document as much information about the individual as possible (name, former sponsor's name, SSN, service and status, as well as the individual's current address and telephone number if known). Do not attempt to confiscate the ID card, or in any way restrict the



individual. Recovery of invalid or no-longer-appropriate ID cards is the responsibility of the parent service's investigation/law enforcement personnel. Reports of possible fraud should be reported to the command of the clinic, and to the DEERS Support Office (DSO) in Monterey, CA at (408) 646-1010.

7. Denial of Nonemergency Health Care Benefits for Individuals Not Enrolled in Defense Enrollment Eligibility Reporting System (DEERS).

a. Policy.

- (1) All CONUS USMTFs will deny nonemergency health care to dependent beneficiaries not enrolled in DEERS. The DOD considers USMTFs located in Alaska, Hawaii, and Puerto Rico as being in CONUS. Patients presenting for care are required to have a valid ID card in their possession and meet DEERS enrollment requirements.
- (2) This policy effects only the delivery of nonemergency health care. Under no circumstances are Coast Guard health service personnel to deny emergency medical care or attention because a patient is not enrolled in DEERS.
- (3) Health service personnel in CGMTF's are to conduct the minimum eligibility checks for their facility as set annually by Commandant (G-WKH-1). Whenever possible, prospective checking should be accomplished soon enough to allow for notifying the patient and correcting enrollment problems before a scheduled appointment.
- (4) Patients with valid ID cards, but not enrolled in DEERS, presenting for nonemergency medical care at CGMTFs will be denied care and instructed to seek proper enrollment through their cognizant personnel office.
- (5) Patients who present for nonemergency treatment without a valid ID card and are in the DEERS data base, will not be provided health care without first providing a statement, signed by a verifying personnel officer indicating that they are eligible and providing a reason why a valid ID card is not in their possession. A copy of this statement will be maintained in the clinical record until the individual's eligibility is determined.
- (6) If the beneficiary presenting with or without an ID card is suspected of fraud, refer the case to the district (ole) branch for appropriate investigation.
- (7) Denial of health care benefits represents a serious application of new and complex regulations. Under no circumstances will a person be denied care by the clerk performing the initial eligibility check. The decision to deny care will be made only by clinic administrative officers or by a responsible person so designated in writing by the command.

8. DEERS Eligibility Overrides. The below listed situations will override DEERS data which indicates that a patient is not enrolled or eligible. Unless otherwise stated, all situations assume that the beneficiary possesses a valid ID card:



- a. Dependents Recently Becoming Eligible for Benefits. Patients who have become eligible for benefits within the previous 120 days may be treated upon presentation of a valid ID card. In the case of children under age 10, the parent's ID card may be used. Examples of patients expected to fall under this provision are: spouses recently married to sponsors, newly eligible step children, family members of sponsors recently entering active duty status for a period over 30 days, parents/parents-in-law, or divorced spouses (not remarried) recently determined to be eligible. After 120 days, these beneficiaries will no longer be considered recent.
- b. DD-1172. Application for Uniformed Services Identification Card form. The patient presents an original or a copy of the DD-1172 used for DEERS enrollment and possesses a valid ID card over 120 days old, but is not enrolled in DEERS. This copy of the DD-1172 should be **Certified to be a True Copy** by the ID Card issuing authority which prepared it. It should also contain a telephone number where the certifying individual can be contacted for verification. The person conducting the DEERS check shall contact the issuing personnel office to verify enrollment.
- c. Sponsors Entering Active Duty Status for a Period of Greater than 30 days. If the sponsor is a reservist or guardsman recently ordered to active duty for a period of greater than 30 days, a copy of the active duty orders may be accepted as proof of eligibility for up to 120 days after the beginning of the active duty period.
- d. Newborns. Newborns will not be denied care for a period of one year after birth provided the sponsor is DEERS enrolled and the parent accompanying the infant presents with a valid ID card.
- e. Ineligible due to ID Card Expiration. When the data base shows a patient to be ineligible due to ID card expiration, care may be rendered as long as the patient has a new ID card issued within the previous 120 days.
- f. Sponsor's Duty Station is Outside the 50 United States with an FPO or APO address. Dependents whose sponsors are assigned outside the 50 United States or to a duty station with an APO or FPO address will not be denied care as long the sponsor is enrolled in DEERS.
- g. Survivors. In a small percentage of cases, deceased sponsors may not be enrolled in DEERS. This situation will be evidenced when the MTF does an eligibility check on the surviving beneficiary and does not find the sponsor enrolled or the survivor appears as the sponsor. In either of these situations, if the survivor has a valid ID card, he/she should be treated and referred to the local personnel support activity to correct the DEERS data base. In some situations, surviving beneficiaries who are receiving SBP annuities will be listed in DEERS as sponsor and will be found under their own social security number. These are eligible beneficiaries and should be treated.



- h. Foreign Military Personnel. Foreign military personnel assigned via the personnel exchange program are eligible through public law or other current directives, though not enrolled in DEERS they will be treated upon presentation of a valid ID card.



Figure 2-H-2

TO: Security Maintenance Office

DEERS East Coast Center SITE ID: \_\_\_\_\_ (DEERS) Date: \_\_\_\_\_  
 1600 N. Beauregard St. (Fill in six digits)  
 Alexandria, VA 22311

SUBJECT: Request for Data Base Additions, Deletions, or Changes

FROM: Site Security Manager: \_\_\_\_\_  
                     Rank    Name (Last, First MI)                      SSAN                      Title  
                     Phone #: AV: \_\_\_\_\_ COM: (\_\_\_\_\_) \_\_\_\_\_

Request the indicated actions be taken for the following individuals:

Action

SSAN    Name (Last, First, MI) Duty Location

(MTF Records, HBA, Etc.)

| Action |        | SSN    |  | name |  | duty location |
|--------|--------|--------|--|------|--|---------------|
| Add    | Delete | Change |  |      |  |               |
|        |        |        |  |      |  |               |
|        |        |        |  |      |  |               |
|        |        |        |  |      |  |               |
|        |        |        |  |      |  |               |
|        |        |        |  |      |  |               |

---

Unit OPFAC Code: \_\_\_\_\_ (Signature) \_\_\_\_\_

Base/Installation/Facility

Site Security Manager

- All Site Security Manager's mailing address changes should be entered in this space.
- All items must be completed. Omission of any items may prevent or delay the processing of this form.



**INSTRUCTIONS FOR DEERS TELEPHONE USERS**

A. Telephone Users.

1. Provide your LOGON-ID and Password to the Eligibility Telephone Center operator at: (800) 336-0289 or (800) 368-4416. The hours of operation are 0400-1700 (Pacific Time), Mon-Fri.
2. Approximately every 30 days the Telephone Center operator will ask you to establish a new password. At that time, you will provide the operator a new Password of 5 to 8 characters. It is very important that you remember the new Password you have chosen.
3. If you forget your password, the operator in the Telephone Center will refer you to the Security Maintenance office at (703) 578-5306, or AUTOVON 289-1953. At this time, you will be provided a Temporary Password, which you will then provide to the Eligibility Telephone Center operator on your next inquiry call.
4. The Eligibility Telephone Center operator will enter this Temporary Password into the operator's terminal and then ask for your new password (as in [2] above).

B. Telephone-Based System.

1. Telephone type. The telephone line used for eligibility checks is a rotary In-WATS telephone system. A rotary system means that when one of the lines at the eligibility center is not being used, the incoming call will automatically be transferred to that line. If a busy signal on the rotary line is received, all lines at the eligibility center are being used. If this happens, hang up and try again later.
  - a. Eligibility Check Procedure. When an eligibility center operator answers the telephone, the following procedures to perform a patient's eligibility check will be used:
  - b. Note: When calling, greet the operator and identify the center from where you are calling.
    - (1) You will supply the following information to the operator:
      - (a) Site name and site security code, UCA code (from medical, dental, or pharmacy)
      - (b) DEERS ID (an optional family member prefix and sponsor's Social Security Number)
      - (c) Date of birth of beneficiary if known. If not known, then 999999
      - (d) FROM date (YYMMDD) of medical treatment



Figure 2-H-2 (con'd)

- (e) TO date (YYMMDD) of medical treatment
- (2) The operator will then perform an eligibility inquiry.
- (3) If the patient is found to be on file, the operator will indicate that the patient is enrolled in DEERS and is/is not eligible. When checking eligibility for more than one member of a family, each of the family members must be identified individually.
- (4) If the patient is not found on file, the operator will indicate that the patient does not appear as enrolled in DEERS.
- (5) The procedure is repeated until all patients have been checked, and then the call is ended.

### **SAMPLE ELIGIBILITY CHECK CALL**

The following is an example of DEERS Eligibility Center Telephone Inquiry format:

Operator: Good Morning - DEERS Eligibility Center - May I help you?

Inquirer: Good morning, this is Support Center Alameda, Security Code AC, UCA Code BA, Site Code 10123, inquiring the eligibility of 123 45 6789. The date of birth is 560324. This is a single beneficiary request.

Operator: (enters SSN, DOB, SC, UC, and SITE CODE) What period of eligibility do you wish to check?

Inquirer: 801201 through 801215 (December 1 - 15, 1980)

Operator: The beneficiary is Jane Smith, and she is enrolled and eligible for the period requested. Any more inquiries?

Inquirer: Not at this time. Thank you, good-bye.

Operator: Thank you for calling the DEERS Eligibility Center.



Figure 2-H-3

PERFORMING DEERS CHECKS USING THE COAST GUARD STANDARD TERMINAL

Ref: (a) DEERS Users Guide (UG0100ELR5) of Oct 1987

1. At the Standard Terminal "Command Bar", Type **VT100**, (Go). If you don't have a "Command Bar", see your computer System Manager.
2. To dial-up the DEERS microcomputer access, enter **ATDT8,7033795860**, then press (Return). This command tells the modem to dial the DEERS access number, and should result in a message reading "connect 1200" on your screen. This means your computer and the one at DEERS are talking to on another.
3. Upon "handshake" with the DEERS computer, enter **M** (for Menu), then **VT100** (return).
4. At Security Protection Screen, enter **DEERS** (Return). See also page 2-2 of reference (a).
5. At Transaction Code Screen, enter **LOGN** (Return). Also see page 2-3 of reference (a).
6. At Security Screen, enter **your** User ID in the "LOGON-ID" space, then press **TAB**. See page 2-4 of reference (a).
7. Enter your personal password in the designated area, then press **TAB**. See page 2-4, Step 5 of reference (a).
8. Enter **GIQD** in the "TRAN ID" space, then press Return. See pages 2-4 and 5, steps 6 & 7 of reference (a).
9. At the Main Menu, select the desired activity. For Eligibility checks, see pages 4-1 through 4-19 of reference (a), or as follows:
10. In Activity Code (AC) space, no entry is necessary if you wish to make an eligibility check. See page 4-11 of reference (a). Press "Tab" to continue.
11. Enter your 6 character **Site ID**, then press "Tab".
12. In "UC" block, enter **BA** for Ambulatory Medical Care checks, **CA** for Dental checks, **DA** for Pharmacy checks, or **FN** for TRICARE/HBA checks, then press "Tab". See page 4-12 of reference (a) for other codes.
13. Enter **Sponsor's SSN**, then press "Tab".
14. Enter PATIENT's Date of Birth (DOB) in the following format: **YYYYMMDD**, then press "Tab".
15. In "DDS" block, enter DEERS Dependent Suffix as follows:
  - 01-19 Eligible Dependent Children
  - 20 Sponsor
  - 30-39 Spouse of Sponsor
  - 40-44 Mother of Sponsor
  - 45-49 Father of Sponsor
  - 50-54 Mother-in-Law of Sponsor



55-59 Father-in-Law of Sponsor

60-69 Other Eligible Dependents

70-74 Unknown by DEERS

75 DDS is unknown by Inquirer

98 Service Secretary Designee

#### NOTE

If the DDS code for sponsor (20) is used, only sponsor data will be displayed on the Eligibility Inquiry and Family Display Screens.

In the Treatment Date block, if the treatment dates are not the current date, enter the correct dates in YYYYMMDD format, then press Tab.

16. After completing the SITE, UC, SPON SSN, PAT DOB, and DDS fields, press the ENTER/RETURN key. If there is a record on the data base with the same SSN and patient DOB or a multiple DOB match and a single DDS match, the DEERS Eligibility Screen will be redisplayed, showing the pertinent data on the patient in the lower portion of the screen.
17. Once patient eligibility has been verified, that patient's data can be cleared from the screen by pressing Return.
18. To exit from the DEERS Eligibility Inquiry System:
  - a. Select the appropriate two-character code and enter it into the AC field. The codes are:  
MM - DEERS Inquiry System Main Menu Screen  
SO - Sign Off  
    - (1) If the MM code is used to return to the Main Menu, enter **10** in the activity field to **Sign Off**, then press **Return**.
  - b. Press, Enter (Return) when prompted by the sign-off screen.
  - c. When at the Original screen, enter +++ (return), then AT H (return). (Steps b and c "hang up" the modem link/telephone connection with the DEERS computer)
  - d. Press, **Finish** to return to the Command Bar.



Figure 2-H-4

**SITE-ID INITIAL REQUEST (DEERS)**

SECTION I. (To be completed by the base/installation/facility Site Security Manager).

A new Site-ID is requested \_\_\_\_\_ (base name).

SERVICE/ORGANIZATION (Check X One)

Air Force = F \_\_\_ DOD = D \_\_\_ NOAA = O \_\_\_  
 Army = A \_\_\_ Marine Corps = M \_\_\_ TRICARE = C \_\_\_  
 Coast Guard = P \_\_\_ Navy = N \_\_\_ Public Health = W \_\_\_  
 Other = X \_\_\_

TYPE OF FACILITY (CHECK X One) FACILITY SECTION (Check X One)

Dental Clinic = D \_\_\_ AAFES = S \_\_\_ FINCTR W/Title III = FT \_\_\_  
 Health Clinic = M \_\_\_ AQCESS = G \_\_\_ Med/Dent Rec = R \_\_\_  
 Hospital = H \_\_\_ Army Fin Off = F \_\_\_ Tumor Registry = T \_\_\_  
 Personnel Office = P \_\_\_ Civ Pers Office = C \_\_\_ Other = Z \_\_\_  
 OPFAC code is \_\_\_\_\_

| <b>Sample:</b>                         | <b>Full Mailing Address:</b>               |
|--|--|
| Commander                              | Point of Contact (Title not person's name) |
| Integrated Support Command New Orleans |  |
| Attn: Medical Records                  |  |
| 4640 Urquhart St.                      |  |
| New Orleans, LA 70017-1010             |  |

\*\* This line of address must include a location identifier. For example, "USCG Clinic" is not acceptable; USCG Clinic New Orleans is acceptable.

Requested by (Rank/Name Signature) \_\_\_\_\_ DATE: \_\_\_\_\_  
 (Telephone) Comm ( ) \_\_\_\_\_, FTS \_\_\_\_\_.

SECTIONS II/III. (To be completed by Service Project Officer)

Recommended by: (Rank/Name/Signature) \_\_\_\_\_ Date: \_\_\_\_\_.

**APPLICATIONS:** (Check X One)

ACTUR \_\_\_ ARED \_\_\_ DOLI \_\_\_ OLGR \_\_\_ RAPIDS \_\_\_  
 AQUESS \_\_\_ DMRIS \_\_\_ GIQD \_\_\_ OLPU \_\_\_ Other \_\_\_

**EQUIPMENT** (Check X One) \*Note: Justification must be attached if equipment is required.

CRT \_\_\_ RAPIDS \_\_\_ Telephone Center \_\_\_  
 Facility Equipment \_\_\_ Timeshare \_\_\_

III. 12-Month Workload: (A) Avg Admissions: \_\_\_\_\_, (B) Avg Outpat Visits: \_\_\_\_\_; (C) Dental: \_\_\_\_\_



Figure 2-H-4 (con'd)

SECTIONS IV/V. (To be completed by DCSPO representative

Director, Benefits Policy Division

DEERS and Central Systems Program Office

Six Skyline Place

5109 Leesburg Pike, Suite 502

Falls Church, VA 22041-3201

V.

Inpatient\_\_\_\_\_

Outpatient \_\_\_\_\_

Dental \_\_\_\_\_

The applications above are correct (or changed as indicated), and the equipment is confirmed.  
Eligibility checking requirements are in Section V. Issue Site-ID.

Director, Benefits Policy Division\_\_\_\_\_Date:\_\_\_\_\_

SECTION VI. (To be completed by Security Maintenance, DEERS East Coast Center)

Entered on DEERS Site-ID File by (initials)\_\_\_\_\_DATE \_\_\_\_\_.

Site-ID: \_ \_ \_ \_ \_

Field Service Region \_\_\_\_\_ State or Country (OCONUS).



Figure 2-H-5

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS)  
DIAL-UP ACCESS POLICY

MICROCOMPUTER ACCESS

DEERS can be accessed by telephone by using an IBM PC or AT compatible microcomputer, or the Coast Guard Standard Terminal with the proper software emulation package installed. There are four criteria for microcomputer access to DEERS:

1. Site must have access to an outside commercial touch-tone telephone line.
2. The modem connected to the computer must be Bell 212A compatible.
3. Individuals must have DEERS assigned user-IDs and passwords,
4. An asynchronous communication software package must be installed in the computer. The most common software for the Standard Terminal is the VT-100 emulator.

An asynchronous dial-up environment is used to allow existing asynchronous terminals at military installations to interface with DMSSCNET through a modem. The required modem must be compatible with a Bell 212A capable for 300 or 1200 baud. This equipment will be communicating with a Renex Converter at the DEERS offices. The display terminal should be set up as follows:

1. Line width of 80 characters
2. 24 line screen height.

The asynchronous communications program should be configured as follows:

1. Baud rate of 300 or 1200.
2. Parity of EVEN or MARK
3. Stop bits of one (1)
4. Terminal emulation selections are listed on the Renex menu
5. Word length of seven (7)

The following telephone number is used to dial into the Renex converter box at DEERS. This number has 16 trunk lines, and should normally be available:

(703) 379-5860



Figure 2-H-5 (con'd)

ENSURING HANDSHAKE

The following criteria must be met during the interface test to ensure the handshake (communication between your computer/modem and the DEERS system) is successful:

1. Verify correct hardware and software configuration
2. Conduct a dial-up test using the above telephone number
3. Perform system access procedures to display the DEERS sign-on screen
4. If any problems or questions arise during the initial setup and testing of equipment, call the DMSSC Technical Support Group at (703) 578-5021, -22, or -23.



## Section I - Health Care Facility Definitions.

### 1. Coast Guard Facilities.

- a. Clinic. A health care facility primarily intended to provide outpatient medical service for ambulatory patients. A clinic must perform certain non-therapeutic activities related to the health of the personnel which are necessary to support the operational mission of the unit, such as physical examinations, immunizations, medical administration, and preventive medical and sanitary measures. A clinic staff consists of at least one permanently assigned medical officer and health services technician. The staff may include dentists, nurses, pharmacists, physician assistants and other specialists as required. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for overnight care of patients who do not require complete hospital services (e.g., isolation of patients with communicable diseases) if accredited for that purpose by an external accreditation agency (JCAHO/AAAHHC).
- b. Satellite Facility. A health care facility which is administered by a Coast Guard clinic but is located off-site from the clinic.
- c. Dental Clinic. A facility at a Coast Guard unit for the dental care and treatment of active duty personnel. Dental clinics are staffed with one or more dental officers and health services technicians.
- d. Sick Bay. A small medical treatment facility (afloat or ashore) normally staffed only by health services technicians for the care and treatment of active duty personnel. Civilian health care providers contracted to provide in-house services at these facilities, like any facility, may provide care only within the scope of their contracts. The fact that these civilian health care providers are on board will not change the status of the medical facility.
- e. Super Sickbay. An intermediate size medical care facility (ashore) intended to provide outpatient medical care for active duty personnel. A super sickbay will perform activities related to the health of the personnel, which are necessary to support the operational missions of all units within AOR, such as physical examinations, immunizations, medical administration, and preventive medical and sanitary measures. A super sickbay staff will normally be staffed with one medical officer and three or more health service technicians.

### 2. Department of Defense Medical Facilities.

- a. Nomenclature and Definitions. There are three types of DOD fixed medical treatment facilities: medical centers, hospitals, and clinics. The nomenclature and definitions applicable to the classification of these facilities, as set forth below, are used by the Army, Navy, Air Force, and Marine Corps.



- (1) **Medical Center.** A medical center is a large hospital which has been designed, staffed and equipped to provide health care for authorized personnel, including a wide range of specialized and consultative support for all medical facilities within the geographic area of responsibility and post graduate education in the health professions.
  - (2) **Hospital.** A medical treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of general medicine and surgery, preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic.
  - (3) **Clinic.** A medical treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and outpatient services. A clinic is also intended to perform certain non-therapeutic activities related to the health of the personnel served, such as physical examinations and preventive medicine services necessary to support a primary military mission. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for care of cases which cannot be cared for on an outpatient status, but which do not require hospitalization.
- b. **Primary Mission.** The primary mission of Department of Defense medical facilities is to provide adequate medical care for members of the uniformed services on active duty.

### 3. Uniformed Services Treatment Facilities (USTFs).

- a. Public Law 97-99 (1981) authorized several former USPHS hospitals (sometimes called Jackson Amendment facilities) to provide health care to active duty and retired members and their dependents. The law was modified in 1991 and the USTF program was mandated to implement a managed care delivery and reimbursement model in order to continue as part of the Military Health Services System (MHSS). This managed care plan went into effect on October 1, 1993 and is called the Uniformed Services Family Health Plan (USFHBP).
- b. USFHBP is a health maintenance organization-type of plan exclusively for the dependents of active duty, retirees and their dependents. Where available, the USFHBP serves a defined population, through voluntary enrollment, and offers a comprehensive benefit package. The capacity at USFHBP sites varies and is limited. Beneficiaries enroll in the USFHBP during a yearly **open season**, and may disenroll after one year. Enrollment is confirmed by each USFHP site. Those not accepted during the open season may be enrolled as openings occur on a **first come-first served** basis. **USFHBP enrollees are not authorized to use the TRICARE Program or the direct care system (DOD and Coast Guard health care/dental facilities included) while enrolled in the USFHP.**
- c. Dependents and retirees who do not enroll in the USFHBP or who are denied enrollment because the USFHBP is at capacity can only be treated at USTFs on a



space-available and fee-for-service basis. All USTFs are required to be TRICARE preferred providers.

- d. Active duty personnel are not eligible to enroll in the USFHBP, however, they can still be treated at USTFs under the following conditions:
  - (1) for emergency care,
  - (2) when referred by a military treatment facility, or
  - (3) when authorized by the cognizant MLC for non-emergent care.
- e. When active duty care is rendered, the USTFs are not authorized to bill or collect payment from active duty members, they must bill the Coast Guard instead.



## Section J - Policies and Procedures Required at Coast Guard Health Care Facilities.

1. Administrative Policies and Procedures. All facilities shall develop and maintain the following written administrative policies and procedures which shall be reviewed annually and updated as needed.
  - a. Standard Operating Procedure (SOP) defining objectives and policies for the facility.
  - b. Organizational Chart if there is a Health Services Division or Branch. The Health Services Division/Branch or Medical Department should also be shown on the command's organizational chart.
  - c. Clinic protocols, posted in the respective department, for pharmacy, medical laboratory, and medical and dental radiology.
  - d. Notices posted in pharmacy and radiology advising female patients to notify department personnel if they are or might be pregnant or breast feeding (pharmacy only).
  - e. Written guidelines advising patients how to obtain after-hours emergency medical and dental advice or care. These must be readily available and widely publicized within the command and the local eligible beneficiary community.
  - f. Quality Assurance (QA) program guidelines including assignment of a QA coordinator and QA focus group members in writing. The QA focus group shall meet at least quarterly and maintain written minutes.
  - g. Guidelines for a patient advisory committee (PAC) comprised of representatives of the health care facility and each major, identifiable, patient interest group. The PAC shall meet periodically and maintain written minutes.
  - h. Persons authorized to deny care shall be so designated in writing by the command.
2. Operational Policies and Procedures. Facilities shall also develop and maintain the following written operational policies and procedures. These require annual review and signature by all health services personnel.
  - a. Emergency Situation Bill including Health Services Division response to fire, earthquake, bomb threat, heavy weather, etc.
  - b. Health Services Emergency Response Protocols for suicide attempt/threat, rape/sexual assault, family violence and medical emergencies in the dental clinic.
  - c. Protocol for managing after-hours emergencies. Clinics at accession points and at Coast Guard units with on-base family housing shall maintain a 24-hour live watch schedule.



3. Patient Rights. Health care shall be delivered in a manner that protects the rights, privacy and dignity of the patient. Sensitivity to patient needs and concerns will always be a priority.
  - a. Clinics shall post the Patient Bill of Rights and Responsibilities poster in clear view in all patient waiting and urgent care areas (see Figure 2-J-1). Copies are available from Commandant (G-WKH-1).
  - b. Chaperones shall provide comfort and support to patients during exams or treatment. All patients shall be informed of the availability of chaperones.
    - (1) Chaperones are defined as persons who attend patients during medical exams or treatment. Chaperones shall be of the same gender as the patient being examined. Any nursing staff member, HS or volunteer may serve as a chaperone as part of their duties. The Chief, Health Services Division shall ensure that chaperones have appropriate training or experience (such as Red Cross Orientation/Training) to enable them to carry out their duties properly. Although a patient's request for a family member or friend to be present during examination may be honored, that person is not a substitute for a chaperone.
    - (2) Patients who request the presence of a chaperone shall have their request honored unless, in the opinion of the medical officer, the risk to the chaperone outweighs the benefit to the patient (e.g., during x-ray exposures).
    - (3) Female patients undergoing breast examination or genital/rectal examination or treatment must have a chaperone present during the examination. Male patients may have a chaperone present at the patient's request.
    - (4) If a provider thinks a chaperone is necessary, and the patient refuses to permit the services of a chaperone, the provider must consider whether to perform the examination or treatment or to refer the patient to another source of care.
    - (5) Clinics shall have a written policy for reporting any episode of alleged misconduct during medical/dental examinations to the unit commanding officer. Unit commanding officers shall investigate such complaints in accordance with regulations.
  - c. Chief, health services division shall enforce the patient chaperone policy and ensure chaperones are qualified to perform their duties.
  - d. Chief, health services division shall ensure that allegations of misconduct are forwarded to the command in a timely manner.
  - e. Clinics shall ensure that patient educational materials concerning gender-related health issues (PAP smears, cervical cancer, mammography and breast disease, testicular and prostate cancer, etc.) are readily available.



4. Health Care Provider Identification.

- a. In accordance with the Patient Bill of Rights and Responsibilities, all patients have the right to know the identity and the professional qualifications of any person providing medical or dental care. The recent addition of Nurse Practitioners and commissioned Physician Assistants to our health care staffs has increased the chances of misidentification. Accordingly, health care providers shall introduce themselves and state their professional qualifications (level of provider) at each patient encounter.
- b. The standard Coast Guard name tag does not reflect any information concerning the professional qualifications of the health care provider. Additionally, the standard Coast Guard name tag is often not visible to patients with poor eyesight, or it may be hidden by the provider's smock or lab coat. In lieu of the standard Coast Guard name tag, all health care providers, civilian and military, shall wear a specific health care provider identification tag on their outer smock or lab coat when engaged in direct patient care in Coast Guard Clinics and Dental Clinics. The health care provider identification tag shall be worn above the right breast pocket (or equivalent). The following criteria shall be used by local commands and clinics in manufacturing the health care provider identification tags:
  - (1) Size. The identification tag shall be 1" high by 3" wide.
  - (2) Materials. Standard plastic name tag blanks which may be purchased locally or from Government sources.
  - (3) Color. Standard Coast Guard blue or black with white lettering.
  - (4) Contents. The identification tag shall contain the following information:
    - (a) The rank, first initial, and last name shall be centered on the identification name tag and placed on the top line.
    - (b) One of the following professional titles, or any other commonly recognized professional name, centered below the name line. Abbreviations shall not be used.
      - 1 Physician
      - 2 Dentist
      - 3 Physician Assistant
      - 4 Nurse Practitioner
      - 5 Pharmacist
      - 6 Physical Therapist



- 7 Optometrist
- 8 Registered Nurse
- 9 Health Services Technician



FIGURE 2-J-1



THE COMMANDANT OF THE UNITED STATES COAST GUARD  
WASHINGTON, DC 20583-0001

## PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

### *Patient Rights*

#### *You have a right to:*

Considerate, respectful care with suitable attendants consistent with the health care resources available and the accepted standard of care.

Impartial access to treatment regardless of race, sex, religion, or national origin.

Reasonable safety, comfort, and privacy within the clinic.

The identity and professional status of the health care providers and professionals primarily responsible for your care.

Full disclosure from the provider of care about your condition, treatment, prognosis, significant complications, risks, benefits, alternative treatments available, and any additional information required to give informed consent prior to procedures.

Personal and information privacy within the limits of the law. That is to:

a. refuse to talk with or see anyone not directly involved in your care;

b. be interviewed and examined in surroundings that assure reasonable privacy;

c. expect that any discussion or consultation involving your care will be conducted confidentially; and

d. have your health records read only by individuals who are directly involved in your treatment or the monitoring of its quality or have other legal authority to review your record.

The presence of a chaperone during examination and treatment, if you so desire.

Expect reasonable continuity of care.

Be advised if the facility proposes to engage in, or perform, research associated with your care or treatment. You have a right to refuse to participate in any research project.

Refuse treatment to the extent permitted by law and government regulations, and to be informed of the consequences of your refusal.

Be informed of facility rules and regulations which relate to your conduct.

Receive information concerning the medical or dental treatment facility mechanisms to initiate, review, and resolve potential complaints.

### *Patient Responsibilities*

#### *You have the responsibility:*

To provide complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.

To report any unexpected changes in your condition.

To understand your treatment plan, and to ask questions about what is not clear to you.

To follow the treatment plan.

To keep appointments and to notify the clinic when you are unable to do so.

For your actions if you refuse treatment or do not follow the orders of health care providers.

To inform the facility if you believe your rights have been violated.

To be considerate of the health services personnel and to act in a mature and polite manner.

To be considerate of other patients. In particular, smoking, loud noises, unruly behavior, profanity, and improper attire are not permitted in the clinic.

To promptly return records to the clinic where they are maintained. All health records documenting care provided by any medical or dental treatment facility are the property of the U.S. Government.

*Robert E. Kramek*

ROBERT E. KRAHEK  
Admiral, U.S. Coast Guard



Section K - General Standards of Care. Patients at Coast Guard clinics and sickbays shall be treated in accordance with the following general standards of care:

1. Diagnosis and therapy shall be performed by a provider with appropriate credentials.
2. Diagnoses shall be based upon clinical findings and appropriate tests and procedures.
3. Treatment shall be consistent with the working diagnosis, and shall be based upon a current treatment plan.
4. Treatment shall be rendered in a timely manner. Providers should use their professional judgement in accounting for the specific needs of patients and military readiness obligations while attempting to meet the following goals for timeliness:
  - a. Sick call – If provided, the patient should be triaged immediately and be seen based on urgency of the condition. The patient should be advised of the wait time to be seen and offered a later appointment if the condition does not warrant immediate attention.
  - b. Acute Illness (medical) - The wait time should not exceed 1 day. The condition must be addressed, not necessarily resolved, within this time frame.
  - c. Routine Visit (medical) - The wait time should not exceed 1 week.
  - d. Specialty Care (medical) - To be determined by the primary care manager making the referral based on the nature of the care required and the acuteness of the injury, condition, or illness, but should not exceed a wait time of 4 weeks to obtain the necessary care.
  - e. Well Visit - The wait time should not exceed 4 weeks.
  - f. Urgent Care (dental) - The wait time should not exceed 1 day. The condition must be addressed, not necessarily resolved, within this time frame.
  - g. Routine Visit (dental) - The wait time should not exceed 4 weeks.
  - h. Scheduled Appointment (medical or dental) - The wait time should not exceed 30 minutes of appointed time. This may sometimes be delayed by the need to address prior scheduled patients, emergency care, or unforeseen military obligations.
  - i. Pharmacy - Prescription available within 30 minutes.
5. Treatment shall be provided using currently accepted clinical techniques.
6. Patients shall participate in deciding among treatment alternatives available to them.



7. All diagnosis and treatment shall be appropriately documented, including subjective complaints, pertinent positive and negative history, objective findings, clinical assessment, plan for treatment, prescriptions, post-treatment instructions, and disposition of patient.
8. Unusual circumstances, including complications of treatment, shall be fully documented.



## CHAPTER 3

### PHYSICAL STANDARDS AND EXAMINATION

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## CHAPTER 3. PHYSICAL STANDARDS AND EXAMINATIONS

### Section A - Administrative Procedures.

#### 1. Applicability of Physical Standards.

- a. The provisions of this chapter apply to all personnel of the Coast Guard and Coast Guard Reserve on active or inactive duty and to commissioned officers of the Public Health Service assigned to active duty with the Coast Guard.
- b. Members of the other Armed Forces assigned to the Coast Guard for duty are governed by the applicable instructions of their parent Service for examination standards and for administrative purposes.

#### 2. Prescribing of Physical Standards.

Individuals to be enlisted, appointed, or commissioned in the Coast Guard or Coast Guard Reserve must conform to the physical standards prescribed by the Commandant. Separate standards are prescribed for various programs within the Service.

#### 3. Purpose of Physical Standards.

Physical standards are established for uniformity in procuring and retaining personnel who are physically fit and emotionally adaptable to military life. These standards are subject to change at the Commandant's direction when the needs of the Coast Guard dictate.

#### 4. Application of Physical Standards.

- a. Conformance with Physical Standards Mandatory. To determine physical fitness, the applicant or member shall be physically examined and required to meet the physical standards prescribed in this chapter for the program or specialty and grade or rate involved. An examinee who does not meet the standards shall be disqualified.
- b. Evaluation of Physical Fitness. The applicant's total physical fitness shall be carefully considered in relation to the character of the duties to that the individual may be called upon to perform. Physical profiling is not a Coast Guard policy. Members shall be considered fit for unrestricted worldwide duty when declared physically qualified. The examiner must be aware of the different physical standards for various programs. Care shall be taken to ensure an examinee is not disqualified for minor deviations that are clearly of no future significance with regard to general health, ability to serve, or to cause premature retirement for physical disability. However, conditions that are likely to cause future disability or preclude completing a military career of at least twenty years, whether by natural progression or by recurrences, are also disqualifying. This policy shall be followed when an authentic history of such a condition is established, even though clinical signs may not be evident during the physical examination.



5. Interpretation of Physical Standards. Examiners are expected to use discretion in evaluating the degree of severity of any defect or disability. They are not authorized to disregard defects or disabilities that are disqualifying in accordance with the standards found in this chapter.
6. Definitions of Terms Used in this Chapter.
  - a. Officers. The term "officers" includes commissioned officers, warrant officers, and commissioned officers of the Public Health Service.
  - b. Personnel. The term "personnel" includes members of the Coast Guard and Coast Guard Reserve, and the PHS on active duty with the Coast Guard.
  - c. Medical and Dental Examiners. Medical and dental examiners are medical and dental officers of the uniformed services, contract physicians and dentists, or civilian physicians or dentists who have been specifically authorized to provide professional services to the Coast Guard. Some USMTFs have qualified enlisted examiners who also conduct medical examinations and their findings require countersignature by a medical officer.
  - d. Flight Surgeons and Aviation Medical Officers. Officers of a uniformed service who have been so designated because of special training.
  - e. Command/Unit. For administrative action required on the Report of Medical Examination (SF-88), the command/unit level is the unit performing personnel accounting services for the individual being physically examined.
  - f. Reviewing Authority. Commander Coast Guard Personnel (CGPC-adm) and MLC (K) are responsible for approval of physical examinations as outlined herein. Clinic Administrators may act as reviewing authority for physical examinations performed in their AOR as designated by the cognizant MLC, except for those that are aviation or dive related. Reviewing authority shall not be delegated below the HSC level. Medical Administrative Officers (LDO and CWO-Meds) may review physical examinations performed by contract physicians and USMTFs within their AOR.
  - g. Convening Authority. Convening Authority is an individual authorized to convene a medical board as outlined in Physical Disability Evaluation System, COMDTINST M1850.2 (series).
  - h. Time Limitation. The time limitation is the period for which the physical examination remains valid to accomplish its required purpose. The time limitation period begins as of the day after the physical examination is conducted.
7. Required Physical Examinations and Their Time Limitations.
  - a. Enlistment. A physical examination is required for original enlistment in the Coast Guard and the Coast Guard Reserve. This physical examination will usually be performed by Military Entrance Processing Stations (MEPS) and is valid for twenty-



four months. Approved MEPS physicals do not require further review. Recommendations noted on separation physical examinations from other services must have been resolved with an indication that the individual meets the standards. A certified copy of that physical examination must be reviewed and endorsed by the reviewing authority Commander (CGRC). The reviewing authority must indicate that the applicant meets the physical standards for enlistment in the USCG.

- (1) Recruiters who believe that applicants have been erroneously physically disqualified by MEPS, may submit the SF-88 and SF-93 (original or clean copies) along with supporting medical records to Commander (CGRC) for review.
  - (2) Waiver of physical standards for original enlistment may also be submitted as above, and in accordance with paragraph 3-A-8 of this instruction.
  - (3) Separation physical examinations from any Armed Service may be used for enlistment in the Coast Guard, provided the examination has been performed within the last twelve (12) months. The physical examination must be as complete as a MEPS exam, include an HIV antibody test date (within the last 24 months) and result, and a Type II dental examination. An SF-93 must also be included with elaboration of positive medical history in the remarks section (item #25). Forward all documents for review by Commander (CGRC).
  - (4) Prior Service enlisted aviation personnel must obtain an aviation physical examination from a currently qualified uniformed services flight surgeon or AMO within the previous 12 months. This physical examination will be submitted with the rate determination package to Commander (CGRC).
  - (5) Occasionally, applicants for initial entry into the Coast Guard will need to be examined at Coast Guard MTFs. In these cases, the physical examination will be performed per section 3-C. The examining medical officer may defer item #46 of the SF-88 to the Reviewing Authority. Otherwise, the physical standards for entry (sections 3-D and 3-E, as appropriate) must be meticulously applied when completing this item. The completed SF-88 and SF-93 will be forwarded to the reviewing authority, Commander (CGRC).
- b. Pre-Commissioning/Appointments. A physical examination is required within 12 months prior to original appointment as an officer in the Coast Guard or Coast Guard Reserve for personnel in the following categories:
- (1) appointment to Warrant Grade, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office, form CG-9556.
  - (2) appointment of a Licensed Officer of the U. S. Merchant Marine as a commissioned officer (examination required within 6 months); and
  - (3) upon graduation from the Coast Guard AcSeparation from Active Duty.
- c. Separation from Active Duty.



- (1) A complete physical examination (SF-88/93) is required within 12 months for retirement, involuntary separation, or release from active duty (RELAD) into the Ready Reserves (selected drilling or IRR). The physical examination shall follow the guidelines set forth for quinquennial physicals.
  - (2) Other members separating from the Coast Guard e.g., discharge or transfer to standby reserve (non-drilling) may request a medical and/or dental examination. The medical examination must include: notation of any current problems, a blood pressure measurement, and address items on the preventive medicine stamp. In addition to the above, the practitioner shall ascertain the health needs of the member and undertake measures deemed necessary to meet those needs. The dental examination, if requested, must at least be a Type III exam. These examinations may be annotated on a SF-600, and upon completion, do not require approval.
  - (3) For members enrolled in the Occupational Medical Surveillance and Evaluation Program (OMSEP), see chapter 12 of this Manual for guidance.
  - (4) See chapter 12 of the Personnel Manual, COMDTINST M1000.6(series), for amplification on administrative discharge procedures.
- d. Overseas Transfer/Sea Duty Deployment. A modified screening examination is required for all personnel departing for a overseas assignment for 60 consecutive days or greater, to permanent assignment aboard a Polar Icebreaker, or to a vessel deploying from it's home port for 60 consecutive days or greater. Correction of defects noted on this screening must be corrected IAW Chapter 3-B-4.a of this Manual. Members who are transferring from one overseas duty station to another overseas duty station do NOT require another overseas physical examination. If they are being transferred to a foreign country, an HIV antibody test and dental examination must be completed within 6 months prior to departure. This examination shall be recorded on an SF-600 (per FIGURE 3-A-1) and, together with a copy of the last complete and approved Report of Physical Examination (SF 88) and Report of Medical History (SF 93), shall be submitted to the Reviewing Authority. This examination shall include the following:
- (1) detecting, by Type II dental exam, any dental defects and to allow sufficient time to complete all essential dental treatment to provide personnel a Class I or II status prior to the execution of orders.
  - (2) screening for communicable diseases and ensuring that the PPD is current and the HIV antibody test has been performed and documented within six months prior to departure to foreign country;
  - (3) reviewing the health record to ensure that required physical examinations and all immunizations are up-to-date, and that the interval medical history since last approved complete physical examination is not disqualifying;
  - (4) ensuring that the examinee is corrected to 20/20 (or best correction) and possesses 2 pairs of glasses;



- (5) ensure a qualitative G-6-PD screening has been done on persons being assigned to "Alert Force" status. Record result on Problem Summary List (NAVMED 6150/20). (This test need only be performed once per career); and
- (6) if a member is enrolled (or will be enrolled based on new assignment) in Occupational Medical Surveillance and Evaluation Program (OMSEP), ensure appropriate periodic/basic examination is performed.

e. Applicant.

- (1) Commissioning Programs. A physical examination is required for applicants for entry into the Coast Guard as follows:
  - (a) Coast Guard Academy: DODMERB physical examination within 24 months;
  - (b) Officer Candidate School: MEPS physical within 24 months of entry date, except:
    - 1 Coast Guard personnel on active duty may obtain the physical examination at a USMTF within 24 months of entry date, and
    - 2 Members of other Armed Services may submit a physical examination from a USMTF provided the examination has been performed within the past twelve (12) months and is as complete as a MEPS physical examination.
  - (c) Direct commission: MEPS physical within 24 months of entry date or oath of office for Ready Reserve Direct Commission, except aviation programs, where examination by a uniformed service flight surgeon or AMO is required within 12 months of entry date.
- (2) Aviation. An aviation physical examination is required for applicants for training in all categories of aviation specialties. This physical examination is valid for 24 months for Class II applicants and 12 months for pilot applicants.
- (3) Diving. A physical examination is required for all applicants for duty involving diving, and is valid for twelve months.

f. Pre-Training Screening Examinations. A screening examination is required within 1 week of reporting to the Coast Guard Academy, Officer Candidate School, Direct Commission Officer orientation, or the Recruit Training Center. This screening examination shall be sufficiently thorough to ensure that the person is free from communicable and infectious diseases, and is physically qualified. The results of this examination shall be recorded on an SF-600 and filed in the health record.

g. Retired Members Recalled to Active Duty. A physical examination is required for retired personnel who are recalled to active duty. This physical examination is valid for twelve months. A physical examination performed for retirement may be used



for recall providing the date of recall is within six months of the date of the physical examination.

h. Annual. An annual physical examination is required on all active duty personnel who are 50 years of age or older and all air traffic controllers.

i. Biennial.

(1) Biennial physical examination is required every 2 years after initial designation, until age 48, for the following :

(a) all aviation personnel (except air traffic controllers); and

(b) all Landing Signal Officers (LSO).

(2) The biennial exam will be performed within 90 days before the end of the birth month. The period of validity of the biennial physical will be aligned with the last day of the service member's birth month. (Example: someone born on 3 October would have August, September, and October in which to accomplish his/her physical. No matter when accomplished in that time frame, the period of validity of that exam is until 31 October two years later.)

(3) This process of aligning the biennial exam with the birth month is a new process effective immediately. In order to phase in this process the valid period of future biennial exams may be extended up to a total of thirty months (6 months from the current valid date) to align the valid date with the birth month. (See Table 3-A-1).

(a) Example 1: A member with an October birth month accomplishes biennial exam in May 2000 (previously valid until May 2002). Biennial exam is now valid until October 2002 (29 months total) to allow the member to align biennial exam with birth month.

(b) Example 2: A member with a June birth month accomplishes a biennial exam in October of 1999 (previously valid until October 2001). Biennial exam is now valid until June 2001 (20 months total) to allow the member to align biennial exam with birth month.

(4) The requirement to perform a biennial exam will not be suspended in the event of training exercises or deployment. Aircrew with scheduled deployment during their 90 day window to accomplish their biennial exam may accomplish their biennial exam an additional 90 days prior and continue with the same valid end date. This may result in a member having a valid biennial for 30 months. Members unable to accomplish a biennial exam prior to being deployed will be granted an additional 60 days upon return in which to accomplish their physical. Align subsequent biennial exam with the aircrew member's birth month using Table 3-A-1.

(5) Additionally, a comprehensive physical may be required during a post-mishap investigation, FEB, or as part of a work-up for a medical disqualification.



- (6) Personnel designated as aircrew are expected to maintain a biennial exam schedule regardless of current aviation duty status.

Table-3-A-1

**Number of months for which a biennial exam is valid**

| Birth Month | Month in which last biennial exam was given |     |     |     |     |     |     |     |     |     |     |     |
|-------------|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
|             | JAN   | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
| JAN         | 24  | 23  | 22  | 21  | 20  | 19  | 30  | 29  | 28  | 27  | 26  | 25  |
| FEB         | 25  | 24  | 23  | 22  | 21  | 20  | 19  | 30  | 29  | 28  | 27  | 26  |
| MAR         | 26  | 25  | 24  | 23  | 22  | 21  | 20  | 19  | 30  | 29  | 28  | 27  |
| APR         | 27  | 26  | 25  | 24  | 23  | 22  | 21  | 20  | 19  | 30  | 29  | 28  |
| MAY         | 28  | 27  | 26  | 25  | 24  | 23  | 22  | 21  | 20  | 19  | 30  | 29  |
| JUN         | 29  | 28  | 27  | 26  | 25  | 24  | 23  | 22  | 21  | 20  | 19  | 30  |
| JUL         | 30  | 29  | 28  | 27  | 26  | 25  | 24  | 23  | 22  | 21  | 20  | 19  |
| AUG         | 19  | 30  | 29  | 28  | 27  | 26  | 25  | 24  | 23  | 22  | 21  | 20  |
| SEP         | 20  | 19  | 30  | 29  | 28  | 27  | 26  | 25  | 24  | 23  | 22  | 21  |
| OCT         | 21  | 20  | 19  | 30  | 29  | 28  | 27  | 26  | 25  | 24  | 23  | 22  |
| NOV         | 22  | 21  | 20  | 19  | 30  | 29  | 28  | 27  | 26  | 25  | 24  | 23  |
| DEC         | 23  | 22  | 21  | 20  | 19  | 30  | 29  | 28  | 27  | 26  | 25  | 24  |

**Notes:**

Read down the left column to the examinee's birth month; read across to month of last biennial exam; intersection number is the maximum validity period. When last biennial exam was within the 3 month period preceding the end of the birth month, the validity period will normally not exceed 27 months. When the last biennial exam was for entry into aviation training, for FEB, post-accident, post-hospitalization, etc., the validity period will range from 19 to 30 months. Validity periods may be extended by 1 month only for completion of an examination begun before the end of the birth month.

- j. Quinquennial/Quinquennial Diving. A physical examination is required every five (5) years after entry on all active duty personnel, age 25 through age 50, and for all personnel maintaining a current diving qualification (also note "Diving" in item #5 of SF-88). Quinquennial physical examinations are also required for:
- (1) all Selected Reservists within 30 days of their birth date starting at age 25 continuing until retirement, and
  - (2) reserve officers assigned to the Individual Ready Reserve (IRR) who are on a promotion list.



- (3) Officers in 3-A-7.e.(1)(a) and (b) above must have a current approved physical examination documented by PMIS data base entry prior to being promoted (i.e., a quinquennial physical examination within the last 5 years).
- k. Occupational Medical Surveillance and Evaluation Program (OMSEP). Those individuals who are occupationally exposed to hazardous substances, physical energies, or employed in designated occupations must undergo physical examinations as required by Chapter 12 of this Manual.
- l. Miscellaneous Physical Examinations.
  - (1) Retention. This examination is done at the direction of the commanding officer when there is substantial doubt as to a member's physical or mental fitness for duty.
  - (2) Pre-confinement Physical Screening. In general, personnel who are presented for this screening, who do not require acute medical treatment or hospitalization, are fit for confinement. Cases where a member requires more than routine follow-up medical care, or has certain psychiatric conditions, that may make them unfit for confinement, should be discussed with the chief medical officer (or his/her representative) at the confining facility. Personnel requiring detoxification for alcohol or drug dependency are not fit for confinement; however, members that have been detoxified or that may require rehabilitation alone are fit for confinement. This screening shall be recorded on an SF-600 (per FIGURE 3-A-1) and, together with a copy of the last complete and approved Report of Physical Examination (SF 88) and Report of Medical History (SF 93), shall be submitted to the Reviewing Authority.
  - (3) Post Confinement Physical Examination. Ensure a separation physical examination has been completed prior to the member departing the confining facility. The separation physical shall meet the standards of section 3-F and must be approved by the appropriate MLC(k).
  - (4) Reservists. A district commander may require any reservist attached to a command within that area to undergo a complete physical examination if reasonable doubt exists as to the reservist's physical or mental fitness for duty.
  - (5) Non-Fitness for Duty Determination Physical Examinations. The Chief of Health Services retains the authority and responsibility to determine capability and capacity to conduct non-fitness for duty physical examinations for all eligible beneficiaries.
- m. Annual Command Afloat Medical Screening. Officers and enlisted personnel scheduled to assume command afloat shall undergo a medical screening prior to assignment. The initial screening may be conducted by a medical officer where applicable, or an HS not in the prospective chain of command of the member being screened. Thereafter, all commanding officers and officers-in-charge of afloat units will have an annual command afloat medical screening. This screening will also be performed by a medical officer where available, otherwise, the screening may be performed by a Health Services Technician who IS NOT in the chain of command of



the person being screened. The screening process will include a medical history completed by the member, a visual acuity check, blood pressure measurement, and a thorough review of interval history in the member's health record. Results are to be recorded using the format in Figure 3-A-2. The medical screening form (Figure 3-A-2) and a copy of the last approved SF-88 and SF-93 shall then be forwarded to the appropriate MLC (kma) for review. The MLC (kma) will approve or disapprove the screening using section 3-F (retention standards) as the guiding directive. If a question arises as to the fitness of the individual, the MLC (kma) may request additional information from the examining unit. If the MLC (kma) is unable to render a decision as to the fitness for command, the entire command afloat screening package will be forwarded to Commandant (G-WKH) for final action. The reviewed form shall be returned to the member's command for filing in the member's health record.

- n. Dental Examinations. Annual Type II dental examinations are required for all active duty personnel assigned to commands collocated with dental examiners (i.e., Coast Guard DOs, DOD DOs, or civilian contract dentists).

8. Waiver of Physical Standards.

- a. Definition of Waiver. A waiver is an authorization to change a physical standard when an individual does not meet the physical standards prescribed for the purpose of the examination.
  - (1) Normally, a waiver will be granted when it is reasonably expected that the individual will remain fit for duty and the waiver is in the best interests of the Coast Guard. A service member will not be granted a waiver for a physical disability determined to be not fit for duty by a physical evaluation board approved by the Commandant. In these cases, the provisions for retention on active duty contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series), and the Personnel Manual, COMDTINST M1000.6 (series) apply.
  - (2) If a member is under consideration by the physical disability evaluation system, no medical waiver request shall be submitted for physical defects or conditions described in the medical board. All waiver requests received for conditions described in the medical board will be returned to the member's unit without action.
  - (3) A waiver of a physical standard is not required in a case where a Service member's ability to perform on duty has been reviewed through the physical disability evaluation system and the approved finding of the Commandant is fit for duty.
- b. Authority for Waivers. Commander CGPC-epm (enlisted), CGPC-opm (officers), and CGPC-rpm (reserve) have the sole authority to grant waivers. The decision to authorize a waiver is based on many factors, including the recommendations of the Chief, Office of Health and Safety; the best interest of the Service; and the



individual's training, experience, and duty performance. Waivers are not normally authorized but shall be reviewed by Commander (CGPC) for the following:

- (1) original enlistment in the regular Coast Guard of personnel without prior military service;
- (2) appointment as a Cadet at the Coast Guard Academy; and
- (3) training in any aviation or diving category specialty.

c. Types of Waivers.

- (1) Temporary. A temporary waiver may be authorized when a physical defect or condition is not stabilized and may either progressively increase or decrease in severity. These waivers are authorized for a specific period of time and require medical reevaluation prior to being extended.
- (2) Permanent. A permanent waiver may be authorized when a defect or condition is not normally subject to change or progressive deterioration, and it has been clearly demonstrated that the condition does not impair the individual's ability to perform general duty, or the requirements of a particular specialty, grade, or rate.

d. Procedures for Recommending Waivers.

- (1) Medical Officer. A medical officer who considers a defect disqualifying by the standards, but not a disability for the purpose for which the physical examination is required, shall:
  - (a) enter a detailed description of the defect in Item 73 of the SF-88; and
  - (b) indicate that either a temporary or permanent waiver is recommended.
- (2) Command/Unit Level. When the command receives a Report of Medical Examination (SF-88) indicating that an individual is not physically qualified, the command shall inform the individual that he/she is not physically qualified. The individual shall inform the command via letter of his/her intentions to pursue a waiver. The medical officer is required to give a recommendation on whether the waiver is appropriate and if the individual may perform his/her duties with this physical defect. This recommendation shall be completed on an (SF-502) Narrative Summary. A cover letter stating the command's opinion as to the appropriateness of a waiver, the individual's previous performance of duty, special skills, and any other pertinent information, shall accompany the medical officers report. The waiver request package shall be forwarded directly from the member's unit to Commander CGPC-epm or opm, or Commandant (CGPC-rpm) as appropriate.

- e. Command Action on Receipt of a Waiver Authorization. A command receiving authorization from the Commander CGPC-epm/opm/rpm for the waiver of a physical standard shall carefully review the information provided to determine any duty limitation imposed and specific instructions for future medical evaluations.



Unless otherwise indicated in the authorization, a waiver applies only to the specific category or purpose for which the physical examination is required. A copy of the waiver authorization shall be retained in both the service and health records for the period for which the waiver is authorized. Copies of future SF-88's for the same purpose shall be endorsed to indicate a waiver is or was in effect.

9. Substitution of Physical Examinations.

a. Rule for Substitution of Physical Examinations. In certain circumstances, a physical examination performed for one purpose or category may be substituted to meet another requirement provided the following criteria are met:

- (1) the examinee was physically qualified for the purpose of the previous examination and all the required tests and recommendations have been completed;
- (2) the SF-88 used for substitution bears an endorsement from the Reviewing Authority or Commandant (G-WKH), as appropriate, indicating that the examinee was qualified for the purpose of the previous examination;
- (3) there has been no significant change in the examinee's medical status since the previous examination;
- (4) a review of the report of the previous examination indicates that the examinee meets the physical standards of the present requirement;
- (5) the date of the previous examination is within the validity period of the present requirement; and
- (6) all additional tests and procedures to meet the requirements of the current physical examination have been completed.

b. No substitutions are authorized for the following physical examinations:

- (1) enlistment;
- (2) pre-training; and
- (3) applicants for or designated personnel in special programs (aviation, diving, Academy).

c. Procedures for Reporting Substitution. Substitutions of a physical examination shall be reported by submitting a copy of the SF-88 being used to meet the present requirements with the endorsement illustrated in FIGURE 3-A-1 entered on SF-600, Chronological Record of Medical Care. Retain a copy of the substitution endorsement in the health record.



FIGURE 3-A-1 (revised 05-01)

**SUBSTITUTION/OVERSEAS/SEA DUTY MODIFIED SCREENING EXAMINATION**

DATE: \_\_\_\_\_ NAME \_\_\_\_\_ SS# \_\_\_\_\_

UNIT: \_\_\_\_\_

PURPOSE: \_\_\_\_\_  
(purpose or category for present physical examination requirements)

DATE OF PREVIOUS COMPLETED PHYSICAL: \_\_\_\_\_

STATUS OF RECOMMENDATIONS: \_\_\_\_\_

SUMMARY OF INTERVAL MEDICAL HISTORY: \_\_\_\_\_

SCREEN FOR COMPLETION OF THE FOLLOWING ITEMS/CHECK-OFF ITEM WHEN  
ITEM IS COMPLETED:

\_\_\_\_\_ Date of PPD: \_\_\_\_\_ Result: \_\_\_\_\_  
(within the last 48 months)

\_\_\_\_\_ Immunizations/chemoprophylaxis up-to-date & meet requirements for destination

\_\_\_\_\_ Examinee has 2 pairs of glasses (if required to correct refractive error)

\_\_\_\_\_ G-6-PD Screening (qualitative)

Date: \_\_\_\_\_ Result: \_\_\_\_\_  
(Required for those individuals with no record of testing prior to assignment  
afloat or to malaria-endemic areas. Record results on the Problem Summary  
Sheet)

ADDITIONAL OVERSEAS REQUIREMENTS (CHECK-OFF ITEM WHEN ITEM IS  
COMPLETED):

\_\_\_\_\_ Type II dental exam performed within 6 months of departure and member is  
Dental Class 1 or Class 2 with exception described in 4-C-3.c.(3)(b)8.

\_\_\_\_\_ Date of HIV Antibody Test: \_\_\_\_\_  
(within 6 months prior to departure to foreign countries)

| \_\_\_\_\_ Date DNA sample submitted to repository.

SIGNATURES:

\_\_\_\_\_  
(Signature and title of dental officer)

\_\_\_\_\_  
(Signature and title of medical officer or commanding officer)

\_\_\_\_\_  
(Signature and title of reviewing/approving authority)



**ANNUAL COMMAND AFLOAT MEDICAL SCREENING**

Name: \_\_\_\_\_ Rank/Grade: \_\_\_\_\_

SSAN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Unit OPFAC: \_\_\_\_\_ Unit Name: \_\_\_\_\_ Date of Screening: \_\_\_\_\_

**To be completed by the member:** (use reverse side as needed)

List any significant medical history since your last physical examination or medical screening (describe any illnesses, injuries, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you experienced any significant changes in stress level, mood, or family life? \_\_\_\_\_

YES NO

If yes, describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any alcohol-related problems (including DWI)? \_\_\_\_\_

YES NO

If yes, describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you presently taking any medication (including over-the-counter)? \_\_\_\_\_

YES NO

If yes, list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The information I have provided above is complete and accurate.

\_\_\_\_\_  
(Signature of member) Date: \_\_\_\_\_*The following section is to be completed by health services personnel:*

Review of Health Record performed. Significant findings are: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Best Distant Visual Acuity (with correction, if required): R: \_\_\_\_\_ L: \_\_\_\_\_

Sitting blood pressure: \_\_\_\_\_

**NOTE: ATTACH A COPY OF LAST APPROVED SF-88 AND SF-93**\_\_\_\_\_  
UNIT: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature/Title of medical reviewer)

\_\_\_\_\_  
Date: \_\_\_\_\_

(Signature/MLC reviewer)



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Section B - Reporting, Reviewing, Recommendations, and Actions to be Taken on Reports of Medical Examination (SF-88) and Medical History (SF-93).

1. SF-88 (Report of Medical Examination).
  - a. SF-88 is the proper form for reporting a complete physical examination. SF-88 revised (10-94) is the newest version of the physical examination report and can be obtained through Coast Guard Directives Electronic Library on CGSYS III.
  - b. Detailed instructions for the preparation and distribution of this form are contained in section 4-B of this Manual.
2. SF-93 (Report of Medical History).
  - a. SF-93 is the proper form for reporting a member's medical history. SF-93 (6- 96) is now available through Coast Guard Directives Electronic Library on CGSYS III.
  - b. Detailed instructions on the preparation and distribution of this form are contained in section 4-B of this Manual.
3. Review and Action on Findings and Recommendations of Report of Medical Examination (SF-88).
  - a. Action by the Medical Examiner.
    - (1) Review of Findings and Evaluation of Defects. When the results of all tests have been received and evaluated, and all findings recorded, the examiner shall consult the appropriate standards of this chapter to determine if any of the defects noted are disqualifying for the purpose of the physical examination. When physical defects are found that are not listed in the standards as disqualifying, but that, in the examiner's opinion, would preclude the individual from performing military service or the duties of the program for which the physical examination was required, the examiner shall state that opinion on the report indicating reasons. If in the examiner's opinion, a defect listed as disqualifying is not disabling for military service, or a particular program, the examiner shall indicate the basis for this opinion and recommend a waiver in accordance with the provisions of section A of this chapter.
    - (2) Remediable Defects. When the physical examination of active duty personnel indicates defects that are remediable or that may become potentially disabling unless a specific medical program is followed, the examiner shall clearly state any recommendations. If the examining facility has the capability of correcting the defect or providing extended outpatient follow-up or medical care, tentative arrangements for care shall be scheduled, subject to the approval of the examinee's command. If the examining facility does not have the capabilities of providing the necessary care, tentative arrangements for admission or appointment at another facility shall be scheduled, again subject to the approval of the individual's command.



- (3) Advising the Examinee. After completing the physical examination, the medical examiner will advise the examinee concerning the findings of the physical examination. At the same time, the examinee shall be informed that the examiner is not an approving authority for the purpose of the examination and that the findings must be approved by proper authorities.
- (4) Disposition of Reports. The original SF-88 and the original SF-93, together with any reports of consultations or special testing reports not entered on the SF-88 or SF-93, shall be forwarded to the activity that referred the individual for the physical examination.

b. Review and Action on Reports of Physical Examination by Command.

- (1) Command Responsibility.
  - (a) The command has a major responsibility in ensuring the proper performance of physical examinations on personnel assigned and that physical examinations are scheduled sufficiently far in advance to permit the review of the findings and correction of medical defects prior to the effective date of the action for which the examination is required. The command is also responsible to ensure that the individual complies with the examiner's recommendations and to initiate any administrative action required on a Report of Medical Examination.
  - (b) All SF-88's shall be reviewed by commanding officers, or their designee, to determine that the prescribed forms were used and that all necessary entries were made.
  - (c) When the medical examiner recommends further tests or evaluation, or a program of medical treatment (such as hearing conservation, periodic blood pressure readings, etc.), the command will ensure that these tests or examinations are completed or that the individual is directed to and does comply with the recommended program. When a necessary test, evaluation, or program can be completed within a 60 day period, the unit may hold the SF-88 to permit the forwarding of results. In all cases the command shall endorse the SF-88 to indicate what action has been taken and forward the report to the reviewing authority if the 60 day period cannot be met or has elapsed.
  - (d) Disposition of Reports.
    - 1 If a physical examination is accomplished for a purpose for which the command has administrative action, the original SF-88 and SF-93 and a return self-addressed envelope shall be forwarded to the reviewing authority. No action will be taken to accomplish the purpose for which the physical examination was taken until the endorsed original of the report is returned by the reviewing authority



indicating the examinee meets the physical standards for the purpose of the examination.

- 2 Approved MEPS physicals do not require further review. The original physical (SF-88 and SF-93) will be carried to the training center by the individual.
- 3 If the physical examination is for a purpose requiring the consent or approval of the MLC commander, or Commandant, the procedures previously described for command review and action will be accomplished, except rather than forwarding the report of the examination directly to the reviewing authority, it will be included with other supporting documents (letters, recommendations, etc.) and forwarded through the chain of command.
- 4 Units not using a CGMTF shall send physical examinations to the appropriate CG Clinic (as designated by the cognizant MLC), MLC (k), or CGPC (adm) as appropriate.

c. Action by the Reviewing Authority.

- (1) The Commandant is the final reviewing authority for all physical examinations, except for applicants to the Coast Guard Academy.
- (2) Administratively, MLC (k) acts as the reviewing authority for physical examinations performed on personnel assigned to their Areas except as in (4) and (5) below.
- (3) Another exception to this rule pertains to those flight physicals performed on aviation school students during training that are reviewed and approved by the Navy Operational Medicine Institute (NOMI). NOMI, not MLC (k) will be the approving authority for these physicals. CGPC will remain the waiver approval authority for these physicals, when a waiver is required prior to final approval. Upon completion of flight training and assignment to a Coast Guard unit, the NOMI approved physical will be considered valid until the last day of the member's next birth month. The unit flight surgeon will clear the aviator for all flight related duties based on the NOMI approved flight physical.
- (4) Commander Coast Guard Personnel Command (CGPC-adm) is the reviewing authority for aviator candidate, flight officer candidate, aircrew candidate, and diving candidate physical examinations. Commandant (G-WKS) is also the reviewing authority for OMSEP physical examinations. Commander (CGPC-adm) shall review disapproved MEPS physicals to ensure proper application of physical standards.
- (5) The Department of Defense Medical Examination Review Board (DoDMERB) is the reviewing authority for physical examinations performed on Academy applicants. MEPS is the reviewing authority for physical examinations performed in their facilities.



- (6) Each SF-88 shall be carefully reviewed to determine whether the findings reported indicate the examinee does or does not meet the appropriate physical standards. If further medical evaluation is required to determine that the examinee does meet the standards, or to resolve doubtful findings, the reviewing authority shall direct the commanding officer or recruiting station to obtain the evaluation and shall provide such assistance as may be required.
- (7) The reviewing authority shall endorse the original of the SF-88 indicating whether the examinee does or does not meet the physical standards required. If the examinee does not meet the physical standards, the endorsement shall indicate the particular disqualifying defect or defects. Endorsements can be in the format contained in FIGURE 3-B-1 or use of blocks #44, #46 and signature in block #51 of the SF88 (Rev. 10-94).
- (8) The endorsed original of the physical examination shall be forwarded to the individual's unit for filing in the member's health record.
- (9) Input of physical examination status of personnel into the PMIS system is required. Reviewing Authorities shall collect and submit data regarding all physical examinations/screenings (per paragraph 3-A-7, except subparagraph 3-A-7.f) they review to the appropriate PERSRU on a monthly basis. Data to be collected for transmittal to the PERSRUs is as follows:
  - (a) Member's name;
  - (b) Member's rank/rate;
  - (c) Member's SSAN;
  - (d) Member's unit OPFAC;
  - (e) Date of physical examination;
  - (f) Purpose of examination;
  - (g) Date acted upon by Reviewing Authority; and
  - (h) Status code for physical examination. Status codes are as follows:
    - 1 Code A- member qualified for periodic (biennial, quinquennial, etc.) physical examination.
    - 2 Code D- member qualified for RELAD/discharge/retirement.
    - 3 Code O- member qualified for overseas duty.
    - 4 Code N- member not physically qualified.



d. Disposition of Reports.

- (1) When the individual meets the appropriate physical standards, forward the physical examination as indicated in FIGURE 3-B-2.
- (2) When the individual does not meet the appropriate physical standards and a waiver has been recommended, endorse the physical examination and forward it in accordance with section 3-A-8.
- (3) When the individual is not physically qualified for the purpose of the examination and a waiver is not recommended, the reviewing authority will arrange for the examinee to be evaluated by a medical board and provide administrative action as outlined in Commandant Instruction M1850.2(series).

4. Correction of Defects Prior to Overseas Transfer or Sea Duty Deployment.

- a. Medical Defects. Before an individual departs for an overseas assignment for 60 consecutive days or greater days, to permanent assignment aboard a Polar Icebreaker, or to a vessel deploying from its home port for 60 consecutive days or greater, all remediable medical defects, such as hernias, pilonidal cysts or sinuses requiring surgery, etc., must be corrected. Those defects that are not easily corrected will be referred to Commander CGPC for consideration. These procedures also apply to personnel presently assigned to such vessels. In these cases all necessary corrective measures or waivers will be accomplished prior to the sailing date.
- b. Dental Defects. All essential dental treatment shall be completed prior to overseas transfer or sea duty deployment except those described in 4-C-3.c.(3)(b). Essential dental treatment constitutes those procedures necessary to prevent disease and disabilities of the jaw, teeth, and related structures. This includes extractions, simple and compound restorations, and treatment for acute oral pathological conditions such as Vincent's stomatitis, acute gingivitis, and similar conditions that could endanger the health of the individual during a tour of duty. Missing teeth are to be replaced when occluding tooth surfaces are so depleted that the individual cannot properly masticate food. Elective dental procedures (those that may be deferred for up to twelve months without jeopardizing the patient's health, i.e., Class II patient) need not be completed prior to overseas transfer providing both of the following conditions exist:
  - (1) completion of such elective procedures prior to transfer would delay the planned transfer; and
  - (2) adequate Service dental facilities are available at the overseas base.
- c. Vision Defects. A refraction shall be performed on all personnel whose visual acuity is less than 20/20 in either eye (near or distant) or whose present eyewear prescription does not correct their vision to 20/20. All personnel requiring glasses for correction shall have a minimum of two pair prior to overseas transfer or sea duty deployment. All personnel requiring corrective lenses shall wear them for the performance of duty.



5. Objection to Assumption of Fitness for Duty at Separation

- a. Any member undergoing separation from the service who disagrees with the assumption of fitness for duty and claims to have a physical disability as defined in section 2-A-38 of the Physical Disability Evaluation System, COMDTINST M1850.2(series), shall submit written objections, within 10 days of signing the Chronological Record of Service (CG-4057), to Commander CGPC. Such objections based solely on items of medical history or physical findings will be resolved at the local level. The member is responsible for submitting copies of the following information along with the written objections:
  - (1) Report of Medical Examination (SF-88);
  - (2) Report of Medical History (SF-93);
  - (3) signed copy of the Chronological Record of Service (CG-4057);
  - (4) Appropriate consultations and reports; and
  - (5) "other pertinent documentation."
  - (6) The rebuttal is a member's responsibility and command endorsement is not required.
- b. The file shall contain thorough documentation of the physical examination findings, particularly in those areas relating to the individual's objections. Consultations shall be obtained to thoroughly evaluate all problems or objections the examinee indicates. Consultations obtained at the examinee's own expense from a civilian source shall also be included with the report.
- c. Commander (CGPC) will evaluate each case and, based upon the information submitted, take one of the following actions:
  - (1) find separation appropriate, in which case the individual will be so notified and the normal separation process completed;
  - (2) find separation inappropriate, in which case the entire record will be returned and appropriate action recommended; or
  - (3) request additional documentation before making a determination.

6. Separation Not Appropriate by Reason of Physical Disability. When a member has an impairment (in accordance with section 3-F of this Manual) an Initial Medical Board shall be convened only if the conditions listed in paragraph 2-C-2.(b), Physical Disability Evaluation System, COMDTINST M1850.2(series), are also met. Otherwise the member is suitable for separation.

7. Procedures for Physical Defects Found Prior to Separation

- a. Policy. No person shall be separated from the Service with any disease in a communicable state until either rendered noninfectious, or until suitable provisions have been made for necessary treatment after separation.



- b. Remediable Non-Disqualifying Defects. Remediable physical defects that would not normally prevent the individual from performing the duties of grade or rate shall be corrected only if there is reasonable assurance of complete recovery and sufficient time remaining prior to separation.



FIGURE 3-B-1

DATE REVIEWERS UNIT \_\_\_\_\_

Does/does not meet the physical standards for (title or category or purpose of examination), as prescribed in (appropriate section of Medical Manual, COMDTINST M6000.1 (series)).

Disqualifying Defects:

Signature and Title of Reviewer



FIGURE 3-B-2

| <b>Physical Exam Purpose</b>  | <b>Note:</b> | <b>Original to:</b> | <b>Reviewing Authority:</b> |
|-------------------------------|--------------|---------------------|-----------------------------|
| Aviator Candidate             | (1,2)        | CGPC-opm            | CGPC-adm                    |
| Aircrew Candidate             | (1,2)        | CGPC-epm            | "                           |
| Diving Candidate              | (1,2)        | CGPC                | "                           |
| Enlistment                    | (2)          | CGRC                | "                           |
| Flight Surgeon (FS)           |              | MLC (k)             | MLC (k)                     |
| FS Candidate                  | (1)          | G-WKH-1             | G-WKH-1                     |
| Aviator                       | (1)          | MLC (k)             | MLC (k)                     |
| Aircrew                       | (1)          | MLC (k)             | MLC (k)                     |
| Diving                        | (1)          | MLC (k)             | MLC (k)                     |
| Flight Officer                | (1)          | MLC (k)             | MLC (k)                     |
| Annual                        | (1)          | MLC (k)             | MLC (k)                     |
| LSO                           | (1)          | or                  | or                          |
| Quinquennial                  | (1)          | Clinic              | Clinic                      |
| Overseas/Sea Duty             | (1)          | Administrator       | Administrator               |
| Retention                     | (1)          | "                   | "                           |
| Retirement                    | (1,4)        | "                   | "                           |
| Involuntary                   |              |                     |                             |
| Separation                    | (1,4)        | "                   | "                           |
| RELAD                         | (1,4)        | "                   | "                           |
| Precom/Appts                  | (1)          | "                   | "                           |
| Direct Commission             | (1,5)        | CGRC                | CGPC-adm                    |
| OCS                           | (1,5)        | CGRC                | CGPC-adm                    |
| Physician Assistant Candidate | (1,5)        | CGPC-opm            | CGPC-adm                    |

NOTES:

CGRC address: CG Recruiting Command, 4200 Wilson Blvd., Suite 450, Arlington, VA. 22203-1804

- (1) The reviewing authority shall review, endorse and return the original to the member's unit for filing in the member's or applicant's health record.
- (2) Forward the unendorsed physical to the appropriate Headquarters Office (as listed above) with the application/training request package. That Office will forward the physical to Coast Guard Personnel Command for review.
- (3) Forward the original and one copy to Commandant (G-WKH) for review
- (4) Ensure that a completed CG-4057 accompanies the completed SF-88 and SF-93.
- (5) Reviewing authority for current USCG or USCGR members only. For all others, Note (2) above applies. Forward a copy of the first/front page of the SF-88 with endorsement to the appropriate Headquarters office with the application package.



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## Section C - Medical Examination Techniques And Lab Testing Standards.

1. Scope.  
This section is a medical examination technique guide applicable for all physical examinations.
2. Speech Impediment.  
Administer the "Reading Aloud Test" (RAT) as listed.
  - a. Have the examinee stand erect, face you across the room and read aloud, as if confronting a class of students.
  - b. If the individual pauses, even momentarily, on any phrase or word, immediately and sharply say, "What's that?", and require the examinee to start over again with the first sentence of the test.
  - c. On the second trial, The person who truly stammers usually will halt again at the same word phonetic combination often revealing serious stammering. Examinees who fail to read the test without stammering after three attempts will be disqualified.
  - d. READING ALOUD TEST "You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat usually minus several buttons; yet he still thinks as swiftly as ever. A long, flowing beard clings to his chin, giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in the winter when the ooze or snow or ice is present, he slowly takes a short walk in the open air each day. We have often urged him to walk more and smoke less, but he always answers, 'Banana Oil.' Grandfather likes to be modern in his language."
3. Head, Face, Neck, and Scalp (Item 17 of SF-88).
  - a. Head and Face. Carefully inspect and palpate the head and face for evidence of injury, deformity, or tumor growth. Record all swollen glands, deformities, or imperfections noted. Inquire into the cause of all scars and deformities. If a defect is detected such as moderate or severe acne, cysts, or scarring, make a statement as to whether this defect will interfere with wearing military clothing and equipment.
  - b. Neck. Carefully inspect and palpate for glandular enlargement, deformity, crepitus, limitations of motion, and asymmetry; palpate the parotid and submaxillary regions, the larynx for mobility and position, the thyroid for size and nodules, and the supraclavicular areas for fullness and masses. If enlarged lymph nodes are detected describe them in detail with a clinical opinion of their etiology.
  - c. Scalp. Examine for deformities such as depressions and exostosis.



4. Nose, Sinuses, Mouth, and Throat (Item 17 of SF-88).
  - a. If there are no nasal or sinus complaints, simple anterior rhinoscopy will suffice, provided that in this examination, the nasal mucous membrane, the septum, and the turbinates appear normal. If the examinee has complaints, a more detailed examination is required. Most commonly, these complaints are external nasal deformity, nasal obstruction, partial or complete on one or both sides; nasal discharge; postnasal discharge; sneezing; nasal bleeding; facial pain; and headaches.
  - b. Abnormalities in the mucous membrane in the region of the sinus ostia, the presence of pus in specific areas, and the cytologic study of the secretions may provide valuable information regarding the type and location of the sinus infection. Evaluate tenderness over the sinuses by transillumination or x-ray. Examination for sinus tenderness should include pressure applied over the anterior walls of the frontal sinuses and the floors of these cavities and also pressure over the cheeks. Determine if there is any tenderness to percussion beyond the boundaries (as determined by x-ray) of the frontal sinuses. Note any sensory changes in the distribution of the supra-orbital or infra-orbital nerves that may indicate the presence of neoplasm. Note any external swelling of the forehead, orbit, cheek, and alveolar ridge.
  - c. Many systemic diseases manifest themselves as lesions of the mouth and tongue; namely leukemia, syphilis, agranulocytosis, pemphigus, erythema multiform, and dermatitis medicamentosa. Note any abnormalities or lesions on lips or buccal mucous membrane, gums, tongue, palate, floor of mouth, and ostia of the salivary ducts. Note the condition of the teeth. Pay particular attention to any abnormal position, size, or the presence of tremors or paralysis of the tongue and the movement of the soft palate on phonation.
  - d. Record any abnormal findings of the throat. If tonsils are enucleated, note possible presence and position of residual or recurrent lymphoid tissue and the degree of scarring. If tonsils are present, note size, presence of pus in crypts, and any associated cervical lymphadenopathy. Note presence of exudate, ulceration, or evidence of neoplasm on the posterior pharyngeal crypts. Describe any hypertrophied lymphoid tissue on the posterior pharyngeal wall or in the lateral angle of the pharynx and note if there is evidence of swelling that displaces the tonsils, indicating possible neoplasm or abscess. Perform direct or indirect laryngoscopy if the individual complains of hoarseness.
5. Ears (General) and Drums (Item 17 of SF-88). Inspect the auricle, the external canal, and the tympanic membrane using a speculum and good light. Abnormalities (congenital or acquired) in size, shape, or form of the auricles, canals, or tympanic membranes must be noted, evaluated, and recorded.
  - a. Auricle. Note deformities, lacerations, ulcerations, and skin disease.
  - b. External canal. Note any abnormality of the size or shape of the canal and inspect the skin to detect evidence of disease. If there is material in the canal, note whether it is normal cerumen, foreign body, or exudate. Determine the source of any exudate.



in the canal. If this exudate has its origins in the middle ear, record whether it is serous, purulent, sanguinous, or mucoid; whether it is foul smelling; and, whether it is profuse or scanty.

- c. Tympanic membrane. Remove all exudate and debris from the canal and tympanic membrane before examination. Unless the canal is of abnormal shape, visualize the entire tympanic membrane and note and record the following points.
  - (1) List any abnormality of the landmarks indicating scarring, retraction, bulging, or inflammation.
  - (2) Note whether the tympanum is air containing.
  - (3) List any perforations, giving size and position, indicating whether they are marginal or central, which quadrant is involved, and whether it is the flaccid or the tense portion of the membrane that is included.
  - (4) Attempt, if the tympanic membrane is perforated, to determine the state of the middle ear contents, particularly concerning hyperplastic tympanic mucosa, granulation tissue, cholesteatoma, and bone necrosis. Do the pathological changes indicate an acute or chronic process? This clinical objective examination should permit evaluating the infectious process in the middle ear and making a reasonably accurate statement regarding the chronicity of the infection; the extent and type of involvement of the mastoid; the prognosis regarding hearing; and, the type of treatment (medical or surgical) that is required.
  - (5) Note, for all aviation and dive physical examinations, whether the examinee can properly auto insufflate tympanic membrane.

6. Eyes (General), Ophthalmoscopic, and Pupils (Item 17 of SF-88).

External and ophthalmoscopic examinations of the eyes are required on all examinations. Contact lenses shall not be worn during any part of the eye examination, including visual acuity testing. It is essential that such lenses not be worn for 72 hours preceding examination. The strength of the contact that an examinee may possess shall not be accepted as the refraction nor will it be entered as such in Item 60, SF-88. The general examination shall include the following specific points and checks:

a. General.

- (1) Bony abnormality or facial asymmetry.
- (2) Position of the eyes.
- (3) Exophthalmus.
- (4) Manifest deviation of the visual axis.
- (5) Epiphora or discharge.
- (6) Position of puncta or discharge when pressure exerted over lacrimal sac.



- b. Lids.
  - (1) Ptosis.
  - (2) Position of lashes, eversion or inversion.
  - (3) Inflammation of margins.
  - (4) Cysts or tumors.
- c. Conjunctiva. Examine the palpebral and bulbar conjunctiva by:
  - (1) eversion of upper lid;
  - (2) depression and eversion of lower lid; and
  - (3) manually separating both lids.
- d. Pupils.
  - (1) Size.
  - (2) Shape.
  - (3) Equality.
  - (4) Direct, consensual, and accommodative reactions.
- e. Directly and obliquely examine the :
  - (1) Cornea. For clarity, discrete opacities, superficial or deep scarring, pannus, vascularization, pterygium, and the integrity of the epithelium.
  - (2) Anterior Chamber. For depth, alteration of normal character of the aqueous humor, and retained foreign bodies.
  - (3) Iris. For abnormalities and pathologic changes.
  - (4) Crystalline Lens. For clouding or opacities.
- f. Ophthalmoscopic.
  - (1) Media. Examine with a plano ophthalmoscopic lens at a distance of approximately 18 to 21 inches from the eye. Localize and describe any opacity appearing in the red reflex or direct examination or on eye movement.
  - (2) Fundus. Examine with the strongest plus or weakest minus lens necessary to bring optic nerve into sharp focus. Pay particular attention to the color, surface, and margin of the optic nerve, also record any abnormality of the pigmentation or vasculature of the retina.
  - (3) Macula. Examine for any change.



7. Ocular Motility (Item 17 of SF-88).

- a. Ascertain the motility of the eyeballs by testing for binocular eye movement (ductions and versions) in the cardinal positions of gaze. If any abnormalities are suspected, verify with the cover/uncover test.
- b. Observe if the eyes move together and whether there is loss of motion in any direction (paralysis or paresis), or absence of muscle balance, whether latent (heterophoria) or manifest (strabismus). Have the examinee look at a test object and alternately cover and uncover one eye leaving the other uncovered and observe the movement, if any, in each eye. In heterophoria movement occurs only in the eye that is covered and uncovered; on being covered, it deviates and on being uncovered, it swings back into place to take up fixation with the other eye that has remained uncovered.

8. Lungs and Chest (Item 17 of SF-88).

- a. A thorough examination includes a complete history (SF-93) careful physical examination, and necessary x-ray and laboratory studies. In screening examinations, the history and x-ray studies are the most immediately revealing examination techniques.
- b. Remember that several disqualifying diseases such as tuberculosis and sarcoidosis may not be detectable by physical examination and the absence of abnormal physical signs does not rule out disqualifying pulmonary disease. Such diseases, as well as others (neoplasms and fungus infections), may be detected only by chest x-ray.
  - (1) Conduct the physical examination in a thorough, systematic fashion. Take particular care to detect pectus abnormalities, kyphosis, scoliosis, wheezing, persistent rhonchi, basilar rales, digital clubbing, and cyanosis. Any of these findings require additional intensive inquiry into the patient's history if subtle functional abnormalities or mild asthma, bronchitis, or bronchiectasis are to be suspected and evaluated. The physical examination shall include the following.
    - (a) Inspection. The examinee should be seated in a comfortable, relaxed position with the direct light falling upon the chest. Careful comparison of the findings elicited over symmetrical areas on the two sides of the chest gives the most accurate information regarding condition of the underlying structures. Observe for asymmetry of the thoracic cage, abnormal pulsation, atrophy of the shoulder girdle or pectoral muscles, limited or lagging expansion on forced inspiration. The large, rounded relatively immobile "barrel" chest suggests pulmonary emphysema.
    - (b) Palpation.
      - 1 Observe for tumors of the breast or thoracic wall, enlarged cervical, supraclavicular, or axillary lymph nodes, suprasternal notch, and thrills associated with respiration or the cardiac cycle.



- 2 In addition to the breast examinations with periodic physical examinations, an annual clinical breast examination is required for all active duty females aged 40 and above. Monthly self-examination is recommended for all adult female patients.
- (c) Auscultation. Instruct the examinee to breathe freely but deeply through the mouth. Listen to an entire respiratory cycle before moving the stethoscope bell to another area. Note wheezing, rales, or friction rubs. Compare the pitch and intensity of breath sounds heard over symmetrical areas of the two lungs. Instruct the examinee to exhale during this process. Note any rales, paying particular attention to moist rales that "break" with the cough or fine rales heard at the beginning of inspiration immediately after cough.
- (2) Do not hesitate to expand the history if abnormalities are detected during examination or in repeating the examination if chest film abnormalities are detected.
- c. There are three conditions that are most often inadequately evaluated and result in unnecessary and avoidable expense and time loss. These three are asthma (to include "asthmatic bronchitis"), bronchiectasis, and tuberculosis.
- (1) Asthma. In evaluating asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. If documentation of asthma after age 12 is obtained from the evaluatee's physician, this shall result in rejection even though physical examination is normal. Ask about the use of prescription or over-the-counter bronchodilators.
- (2) Bronchiectasis. Individuals who report a history of frequent respiratory infections accompanied by purulent sputum or multiple episodes of pneumonia should be suspected of bronchiectasis. This diagnosis can be further supported by a finding of post-tussive rales at one or both bases posteriorly or by a finding of lacy densities at the lung base on the chest film. If bronchiectasis is considered on the basis of history, medical findings or chest film abnormalities, seek confirmatory opinion from the examinee's personal physician or refer the examinee to the appropriate chest consultant for evaluation and recommendations.
- (3) Tuberculosis (TB).
- (a) Active TB is often asymptomatic and not accompanied by abnormal physical findings unless the disease is advanced. If only such manifestations as hemoptysis or draining sinuses are looked for, most cases of TB will be missed.
- (b) The most sensitive tool for detecting early TB is the PPD.



- (c) If positive, evaluate the chest film for any infiltrate, cavity, or nodular lesion involving the apical or posterior segments of an upper lobe or superior segment of a lower lobe. Many tuberculosis lesions may be partially hidden or obscured by the clavicles. When any suspicion of an apical abnormality exists, an apical lordotic view must be obtained for clarification.
- (d) It is neither practical nor possible, in most instances, to determine whether or not a TB lesion is inactive on the basis of a single radiologic examination. Therefore, refer any examinee suspected of TB to a chest consultant or to an appropriate public health clinic for evaluation.
- (e) An initial PPD is mandatory and shall be made a part of the physical examination for all personnel entering on active duty for a period of 30 days or more.
- (f) See Chapter 7 for complete details of the Tuberculosis Control Program.

9. Heart and Vascular System (Items 17 of SF-88).

- a. General. In direct light, have the examinee stand at ease, with arms relaxed and hanging by sides. Do not permit the examinee to move from side to side or twist to assist in the examination, as these maneuvers may distort landmarks; and increase muscular resistance of the chest wall. Examine the heart by the following methods: inspection, palpation, auscultation, and when considered necessary, by mensuration.
- b. Inspection. Begin from above and go downward, with special reference to the following:
  - (1) any malformation that might change the normal relations of the heart;
  - (2) pulsations in the suprasternal notch and in the second interspaces to the right and left of the sternum;
  - (3) character of the precordial impulse; or
  - (4) epigastric pulsations.
- c. Palpation. First palpate to detect thrills over the carotids, thyroid glands, suprasternal notch, apex of the heart, and at the base. Use palms of hands in palpating and use light pressure, as hard pressure may obliterate a thrill. To locate the maximum cardiac impulse, have the examinee stoop and throw the shoulders slightly forward, thus bringing the heart into the closest possible relation with the chest wall. Palpate both radial arteries at the same time for equality in rate and volume. Run the finger along the artery to note any changes in its walls. Place the palm of one hand over the heart and fingers of the other over the radial artery to see if all ventricular contractions are transmitted. Palpate to determine the degree of tension or compression of the pulse. In an estimate of pulse rate, the excitement of undergoing a physical examination must be considered.



- d. Auscultation. In auscultating the heart, bear in mind the four points where the normal heart sounds are heard with maximum intensity:
- (1) Aortic area, second interspace to right of sternum. Here the second sound is distinct.
  - (2) Tricuspid area, junction of the fifth right rib with the sternum. Here the first sound is distinct.
  - (3) Pulmonic area, second interspace to left of sternum. Here the second sound is most distinct.
  - (4) Mitral area, fifth interspace to left of sternum. Here the first sound is most clearly heard.
- e. Blood Pressure.
- (1) Only the sitting blood pressure is required.
  - (2) Other positions required only if sitting blood pressure exceeds **159/90 (140/90)** for aviation personnel).
  - (3) Take the sitting blood pressure with the examinee comfortably relaxed in a sitting position with legs uncrossed and the arm placed on a rest at the horizontal level of the heart. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as well as the relation between the systolic and diastolic pressure.
  - (4) Personnel recording blood pressure must be familiar with situations that result in spurious elevation. A medical officer shall repeat the determination in doubtful or abnormal cases and ensure that the proper recording technique was used.
  - (5) Artificially high blood pressure may be observed as follows.
    - (a) If the compressive cuff is too loosely applied.
    - (b) If the compressive cuff is too small for the arm size. Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual, this may require an "oversize" cuff.
    - (c) If the blood pressure is repetitively taken before complete cuff deflation occurs. Trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure.
  - (6) At least five minutes of rest should precede the blood pressure recording. Due regard must be given to physiologic effects such as excitement, recent exercise, smoking or caffeine within the preceding thirty minutes, and illness.
  - (7) No examinee shall be rejected based on the results of a single recording. If **2** out of the 3 positions exceed **159/90**, the disqualifying blood pressures will be rechecked for 3 consecutive days in the morning and afternoon of each day and



carefully recorded. The first determination shall be recorded in Item 26 and the repeat determinations in Item 42 of SF-88.

- (8) While emphasizing that a diagnosis of elevated blood pressure not be prematurely made, it seems evident that a single "near normal" level does not negate the significance of many elevated recordings.

f. Blood Pressure Determination.

- (1) Use procedures recommended by the American Heart Association.
- (2) Take the systolic reading as either the palpatory or auscultatory reading depending on which is higher. In most normal subjects, the auscultatory reading is slightly higher.
- (3) Record diastolic pressure as the level at which the cardiac tones disappear by auscultation. In a few normal subjects, particularly in thin individuals and usually because of excessive stethoscope pressure, cardiac tones may be heard to extremely low levels. In these instances, if the technique is correct and there is no underlying valvular defect, a diastolic reading will be taken at the change in tone.
- (4) Note variations of blood pressures with the position change if there is a history of syncope or symptoms to suggest postural hypertension.
- (5) Obtain blood pressure in the legs when simultaneous palpation of the pulses in upper and lower extremities reveals a discrepancy in pulse volume.

g. Pulse Rate.

- (1) Determine the pulse rate immediately after the blood pressure. Only the sitting position is required.
- (2) In the presence of a relevant history, arrhythmia, or a pulse of less than **50** or over **100**, all pulses shall be determined and an electrocardiogram obtained.

h. Interpretation of Abnormal Signs and Symptoms. The excitement of the examination may produce violent and rapid heart action often associated with a transient systolic murmur. Such conditions may erroneously be attributed to the effects of exertion; they usually disappear promptly in the recumbent posture. Try to recognize the excitable individuals and take measures to eliminate psychic influences from the test.

i. Hypertrophy-Dilatation. An apex beat located at or beyond the left nipple line, or below the sixth rib, suggests an enlargement sufficient to disqualify for military service. Its cause, either valvular disease or hypertension in the majority of cases, should be sought. A horizontal position of the heart must be distinguished from left ventricular enlargement. EKG, ultrasound studies, fluoroscopy, and chest x-ray may be indicated for diagnosis.

j. Physiological Murmurs. Cardiac murmurs are the most certain physical signs by which valvular disease may be recognized and its location determined. The



discovery of any murmur demands diligent search for other evidence of heart disease. Murmurs may occur, however, in the absence of valvular lesions or other cardiac disease. Such physiological murmurs are not causes for rejection.

- (1) Characteristics. The following characteristics of physiological murmurs will help differentiate them from organic murmurs.
  - (a) They are always systolic in time.
  - (b) They are usually heard over a small area, the most common place being over the pulmonic valve and mitral valve.
  - (c) They change with position of the body, disappearing in certain positions. They are loudest usually in the recumbent position and are sometimes heard only in that position.
  - (d) They are transient in character, frequently disappearing after exercise.
  - (e) They are usually short, rarely occupying all of the systole, and are soft and of blowing quality.
  - (f) There is no evidence of heart disease or cardiac enlargement.
- (2) Most Common Types. The most common types of physiological murmurs are:
  - (a) Those heard over the second and third left interspaces during expiration, disappearing during forced inspiration. These are particularly common in individuals with flexible chests, who can produce extreme forced expiration. Under such circumstances, murmurs may be associated with a vibratory thrust.
  - (b) Cardio-respiratory murmurs caused by movements of the heart against air in a part of the lung overlapping the heart. They usually vary in different phases of respiration and at times disappear completely when the breath is held.
  - (c) Prolongations of the apical first sound, that are often mistaken for murmurs.
- (3) Diagnosis. An EKG, chest x-ray, and echocardiogram are usually indicated to firmly establish the true cause of a murmur and should be done if there is any question of abnormality.

k. Electrocardiograms. Use standard positions for precordial leads when completing electrocardiograms.

10. Abdomen and Viscera (Item 17 of SF-88).

- a. Examine the abdomen with the examinee supine, as well as standing to detect hernias.



- b. Use appropriate clinical laboratory, radiologic, and endoscopic examinations to confirm a diagnosis.
- 11. Anus and Rectum (Item 17 of SF-88). All examinations shall include a visual inspection of the anus. Perform a digital rectal examination and test for fecal occult blood on all personnel beginning at age 40 and at any time history or physical exam findings indicate. When anorectal disease is suspected a complete exam should be performed which may include proctosigmoidoscopy as indicated.
- 12. Endocrine System (Item 17 of SF-88). Evaluate endocrine abnormalities during the general clinical examination. Palpate the thyroid for abnormality and observe the individual for signs of hyperthyroidism or hypothyroidism. Observe general habitus for evidence of endocrine dysfunction.
- 13. Genitourinary System (Item 17 of SF-88).
  - a. General. All physical examinations shall search for evidence of STD or malformation.
  - b. Instructions for examination according to sex.
    - (1) Females. The examination shall include:
      - (a) inspection of the external genitalia;
      - (b) either a vaginal or rectal bimanual palpation of the pelvic organs; and
      - (c) Papanicolaou (PAP) testing and visualization of the cervix and vaginal canal by speculum in accordance with section 3-C-20.f.
    - (2) Males. The glans penis and corona will be exposed. The testes and scrotal contents will be palpated and the inguinal lymph nodes will be examined for abnormalities. Palpate the inguinal canals while having the patient perform a valsalva.
- 14. Extremities (Items 17 of SF-88). Carefully examine the extremities for deformities, old fractures and dislocations, amputations, partially flexed or ankylosed joints, impaired functions of any degree, varicose veins, and edema. In general the examination shall include:
  - a. Elbow. With the examinee holding the upper arms against the body with the forearms extended and fully supinated, observe for the presence of normal carrying angle. Have the examinee flex the elbows to a right angle and keeping the elbows against the body, note ability to fully supinate and pronate the forearms. Test medial and lateral stability by placing varus and valgus strain on the joint with the elbow extended. Test the power of the flexor, extensor, supinator, and pronator muscles by having the examinee contract these muscles against manual resistance. If indicated, x-rays should include antero-posterior and lateral views.



b. Foot.

- (1) Examine the feet for conditions such as flatfoot, corns, ingrown nails, bunions, deformed or missing toes, hyperhidrosis, color changes, and clubfoot.
- (2) When any degree of flatfoot is found, test the strength of the feet by requiring the examinee to hop on the toes of each foot for a sufficient time and by requiring the examinee to alight on the toes after jumping up several times. To distinguish between disqualifying and nondisqualifying degrees of flatfoot, consider the extent, impairment of function, appearance in uniform, and presence or absence of symptoms. Remember, it is usually not the flatfoot condition itself that causes symptoms but an earlier state in which the arches are collapsing and the various structures are undergoing readjustment of their relationships. Report angles of excursion or limitation; comparative measurements; use of orthotics or other supports; and x-ray results if indicated.

c. Hip.

- (1) With the examinee standing, observe the symmetry of the buttocks, the intergluteal clefts, and infragluteal fold. Palpate the iliac crest and greater trochanters for symmetry.
- (2) If abnormalities are suspected, have the examinee stand first on one foot and then the other, flexing the nonweight bearing hip and knee and observing for ability to balance as well as for instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (non-weight bearing) hip. Such a positive Trendelenburg sign necessitates x-ray evaluation.
- (3) While supine have the examinee flex the hip, abduct and adduct the hip and rotate the leg inward. Observe for hesitancy in performing these motions, incomplete range of motion, or facial evidence of pain on motion. Test muscle strength in each position.
- (4) With examinee prone, test for ability to extend each leg with knee extended and test for power in each hip in extension.
- (5) If abnormalities are detected requiring x-rays, obtain an antero-posterior and a lateral view of each hip for comparison.

d. Knee.

- (1) With trousers (skirt/dress), shoes, and socks removed, observe general muscular development of legs, particularly the thigh musculature.
- (2) Have examinee squat, sitting on heels, and observe for hesitancy, weakness, and presence or absence of pain or crepitus.
- (3) With examinee sitting, test for ability to fully extend the knee and test power in extension by applying pressure to the lower leg with knee extended. Compare equality of power in each leg. With knee flexed, test for hamstring power by attempting to pull leg into extension; compare equality of strength in each leg. Palpate entire knee for tenderness. With examinee still sitting on the table



edge, sit and grasp the heel between the knees; then test for cruciate ligament stability by first pulling the tibia anteriorly on the femur and by then pushing the tibia posteriorly on the femur ("Drawer Sign").

- (4) With the examinee supine, mark on each leg a distance of 1 inch above the patella and 6 inches above the patella, making sure this is done with muscles relaxed. Measure circumferences at these levels and note presence or absence of atrophy. Test the medial and lateral collateral ligaments by placing varus and valgus strain on the extended knee. Manipulate the knee through a complete range of flexion and extension, noting any difference between the sides and any abnormal restriction.
- (5) If there is a history of knee injury assess muscular strength, ligamentous stability, and range of motion. Also look for evidence of inflammatory or degenerative processes.
- (6) In the presence of any history of "locking," recurrent effusion, or instability, or when atrophy measured is more than 3/8 inch or when limitation of motion or ligamentous instability is detected, obtain x-rays including an antero-posterior, lateral, and intercondylar view.
- (7) An orthopedic evaluation is required on all recruit physicals if there is evidence of any abnormality.

e. Shoulder.

- (1) With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry, abnormal configuration, or muscle atrophy.
- (2) From the back, with the examinee standing, observe the scapulohumeral rhythm as the arms are elevated from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particularly careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction, and rotation. Compare each shoulder in this respect.
- (3) Test muscle power of abductors, flexors, and extensors of the shoulder, as well as power in internal and external rotation. Have the examinee attempt to lift a heavy weight with arms at the side to establish integrity of the acromioclavicular joint.

f. Wrist and Hand.

- (1) Palpate the wrist for tenderness in the anatomical snuff box often present in undiscovered fractures of the carpal navicular. Observe and compare muscle strength and range of motion, flexion, extension, radial, and ulnar deviation.
- (2) Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor, indicating possible underlying organic disease.



- (3) Have the examinee flex and extend the fingers making sure interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palm.
  - (4) With the hands pronated, observe the contour of the dorsum of the hands for atrophy of the soft tissues between the metacarpals seen in disease or malfunction of peripheral nerves.
  - (5) With the fingers spread, test for strength, and interosseous muscle function by forcing the spread fingers against the resistance of the examinee.
  - (6) If indicated, obtain antero-posterior and lateral x-rays of the wrist, as well as antero-posterior and oblique views of the hand.
15. Spine and Other Musculoskeletal (Item 17 of SF-88). Carefully examine for evidence of intervertebral disc syndrome, myositis, and traumatic lesions of the low back (lumbosacral and sacroiliac strains). If there is any indication of congenital deformity, arthritis, spondylolisthesis, or significant degree of curvature, obtain orthopedic consultation and x-rays.
- (1) Back. With the examinee stripped and standing, note the general configuration of the back, the symmetry of the shoulders, iliac crests and hips, and any abnormal curvature. Palpate the spinous processes and the erector spinae muscle masses for tenderness. Determine absence of pelvic tilt by palpating the iliac crests. Have examinee flex and extend spine and bend to each side, noting ease with which this is done and the presence or absence of pain on motion. Test rotary motion by gripping the pelvis on both sides and having the examinee twist to each side as far as possible.
  - (2) With the examinee sitting on the examining table, test patellar and ankle reflexes and fully extend the knee, note complaints of pain (this corresponds to a 90 degree straight leg raising test in supine position).
  - (3) With the examinee supine, test dorsiflexor muscle power of the foot and toes, with particular attention to power of the extensor hallucis longus. Weakness may indicate nerve root pressure on S1. Flex hip fully on abdomen and knee flexed and determine presence or absence of pain on extremes of rotation of each hip with hip flexed to 90 degrees. Frequently, in lumbosacral sprains of chronic nature, pain is experienced on these motions. Place the heel on the knee of the opposite extremity and let the flexed knee fall toward the table. Pain or limitation indicates either hip joint and/or lumbosacral abnormality.
  - (4) While prone, have the examinee arch the back and test strength in extension by noting the degree to which this is possible.
  - (5) If pain is experienced on back motions in association with these maneuvers or if there is asymmetry or abnormal configuration, back x-rays, including pelvis, should be obtained. These should include antero-posterior, lateral, and oblique views.



16. Identifying Body Marks, Scars, and Tattoos (Item 17 of SF-88).

- a. Examination. Carefully inspect the examinee's body, front and rear, on each side of the median line separately, commencing with the scalp and ending at the foot. Record under the "Notes" section on the face of the SF-88 all body marks, tattoos, and scars useful for identification purposes. Also state if no marks or scars are found.
- b. Description of Body Marks, Scars, and Tattoos.
  - (1) Indicate the size, location, and character of scars, moles, warts, birthmarks, etc.
  - (2) When recording the location of a tattoo, include narrative description of the design. Tattoo transcriptions of words or initials shall be recorded in capital letters. Describe the size of a tattoo regarding its general dimensions only. A statement relative to color or pigment is not required.
  - (3) Note amputations and losses of parts of fingers and toes showing the particular digit injured and the extent or level of absence.
- c. Abbreviations for Body Marks, Scars, and Tattoos.
  - (1) The following are authorized abbreviations for the descriptions or conditions indicated:

|                 |               |                  |
|-----------------|---------------|------------------|
| Amp.-amputation | m. -mole      | w. -wart         |
| f. -flat        | p. -pitted    | VSULA-           |
| fl. fleshy      | r. -raised    | vaccination scar |
| s. -scar smooth | l. -linear    | upper left arm   |
| v. -vaccination | o. -operative | h. -hairy        |
  - (2) Combinations of the above abbreviations are permissible: p.s. 1/2d. - pitted scar 1/2 inch diameter; f.p.s. 1x1/2 - flat pitted scar 1 inch long and 1/2 inch wide; r.h.m. 1/4d. - raised hairy mole 1/4 inch diameter.
  - (3) Do not use abbreviations when describing tattoos since they are likely to be mistaken as signifying tattooed letters.

17. Neurologic (Item 17 of SF-88). Conduct a careful neurological examination being attentive to the following:

- a. Gait. The individual shall: walk a straight line at a brisk pace with eyes open, stop, and turn around; (Look for spastic, ataxic, incoordination, or limping gait; absence of normal associated movements; deviation to one side or the other; the presence of abnormal involuntary movement; undue difference in performance with the eyes open and closed.)
  - (1) stand erect, feet together, arms extended in front; (Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors, or other involuntary movements.)



- (2) touch the nose with the right and then the left index finger, with the eyes closed. (Look for muscle atrophy or pseudohypertrophy, muscular weakness, limitation of joint movement, and spine stiffness.)
- b. Pupils. Look for irregularity, inequality, diminished or absent contraction to light or lack of accommodation.
  - c. Deep Sense (Romberg). Negative, slightly positive, or pronouncedly positive.
  - d. Deep Reflexes: Patellar, Biceps, etc. Record as absent (o), diminished (-), normal (+), hyperactive (++), and exaggerated (+++).
  - e. Sensory Disturbances. Examine sensation by lightly pricking each side of the forehead, bridge of the nose, chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists with a tuning fork. With eyes closed, the examinee shall move each heel down the other leg from knee to ankle. Test sense of movement of great toes and thumb. Look for diminution or loss of vibration and plantar reflexes. When indicated, perform appropriate laboratory tests and x-ray examinations.
  - f. Motor Disturbances. Evidence of muscle weakness, paresis, or any other abnormality.
  - g. Muscular Development. Evidence of atrophy, compensatory hypertrophies, or any other abnormality.
  - h. Tremors. State whether fine or coarse, intentional or resting, and name parts affected.
  - i. Tics. Specify parts affected. State whether they are permanent or due to fatigue or nervous tension.
  - j. Cranial Nerves. Examine carefully for evidence of impaired function or paresis. Remember that some of the cranial nerves are subject to frequent involvement in a number of important diseases, such as syphilis, meningitis, encephalitis lethargica, and injuries to the cranium.
  - k. Psychomotor Tension. Test the ability to relax voluntarily by having the examinee rest the forearm upon your palm then test the forearm tendon reflexes with a percussion hammer.
  - l. Peripheral Circulation. Examine for flushing, mottling, and cyanosis of face, trunk, and extremities. Question as to the presence of localized sweating (armpits and palms) and cold extremities. Carefully study any abnormalities disclosed on the neurological examination and express an opinion as to their cause and significance and whether they are sufficient cause for rejection.



18. Psychiatric (Item 17 of SF-88).

- a. Personality Evaluation. In order to evaluate the adequacy of the examinee's personality for adjustment to the conditions of military service:
  - (1) estimate the examinee's capacity coupled with real respect for personality and due consideration for feelings;
  - (2) conduct the examination in private to encourage open and honest answers; and
  - (3) attempt to discover any difficulties that the examinee may have had with interpersonal relationships at work or during leisure activities.
- b. Diagnosis of Psychiatric Disorders. The diagnosis of most psychiatric disorders depends upon an adequate longitudinal history, supplemented by information obtained from other sources, such as family, physicians, schools, churches, hospitals, social service or welfare agencies, and courts.
- c. Telltale Signs of Psychiatric Disorders. Be watchful for any of the following: inability to understand and execute commands promptly and adequately; lack of normal response; abnormal laughter; instability; seclusiveness; depression; shyness; suspicion; over boisterousness; timidity; personal uncleanliness; stupidity; dullness; resentfulness to discipline; a history of enuresis persisting into late childhood or adolescence; significant nail biting; sleeplessness or night terrors; lack of initiative and ambition; sleep walking; suicidal tendencies, whether bona fide or feigned. Abnormal autonomic nervous system responses (giddiness, fainting, blushing, excessive sweating, shivering or goose flesh, excessive pallor, or cyanosis of the extremities) are also occasionally significant. Note also the lack of responses as might reasonably be expected under the circumstances.
- d. Procedures for Psychiatric Examination
  - (1) Mental and personality difficulties are most clearly revealed when the examinee feels relatively at ease. The most successful approach is one of straightforward professional inquiry, coupled with real respect for the individual's feelings and necessary privacy. Matters of diagnostic significance are often concealed when the examinee feels the examination is being conducted in an impersonal manner or without due concern for privacy.
  - (2) Pay close attention to the content and implication of everything said and to any other clues, and in a matter-of-fact manner, follow-up whatever is not self-evident nor commonplace.
- e. Aviation only.
  - (1) Although this phase of the examination is routinely performed only on candidates for flight training, it may be made part of any aviation physical examination. The objective is to determine the examinee's basic stability, motivation, and capacity to react favorably to the special stresses encountered in flying. Report any significant personality change in an experienced aviator.



- (2) Following the completion of the general examination:
- (3) study carefully the examinee's family history; and
- (4) determine the family's attitude towards flying and the examinee's reaction to the stresses of life in general and emotional response and control.

19. Dental (Item 18 of SF-88).

a. Who May Conduct Dental Examinations.

- (1) For Academy, OCS, and direct commission applicants: a Uniformed Services dental officer.
- (2) For all aviation, diving, and overseas/sea duty physical examinations: a Uniformed Services dental officer or a contract dentist.
- (3) For all others: a Uniformed Services dental officer, a contract dentist, or a medical examiner if a dentist is unavailable.

b. Procedures for Conducting Dental Examinations.

- (1) Applicants for Original Entry. Whenever practical, applicants for original entry into the Service shall be given a Type 2 dental examination. Otherwise, the dental officer shall determine the type of examination that is appropriate for each examinee.
- (2) Active Duty Personnel. Members on active duty, who are assigned to locations where Coast Guard, USMTF, or civilian contract dental clinics are available shall be required to have an annual Type 2 dental examination.
- (3) Reserve Personnel.
  - (a) Type 2 dental examination is required for Quinquennial Physical Examinations, and
  - (b) Type 2 dental examination is required for all entries onto Active Duty (any type) for periods of duty in excess of 139 days.

c. Dental Restorations and Prostheses. The minimum number of serviceable teeth prescribed for entry in various programs of the Service is predicated on having retentive units available to provide for the reception of fixed bridges or partial dentures that may be necessary for satisfactory masticatory or phonetic function. Prostheses already present should be well-designed, functional, and in good condition.

20. Laboratory Findings (Items 19 of SF-88).

- a. Required Tests. Personnel undergoing physical examinations are required to have the following tests performed, except where obtaining them is not possible or expeditious, or incurring charges for them is not authorized. In such cases, these tests shall be obtained at the first duty station where facilities are available. The normal values listed below are for guidance. Abnormal laboratory values alone are



not disqualifying; however, the causative underlying condition may be. Minimal deviations may not require further evaluation and this should be noted as NCD (not considered disqualifying) in item 74 by the examiner. Normal variants should be noted as such.

b. Hematology/Serology.

- (1) Hematology. Perform a hematocrit (HCT) or hemoglobin (HGB) on all examinees. Perform other hematological studies only as indicated.
- (2) Red Blood Cell Measurements.
- (3) Hemoglobin - Males 13-18 gm/100ml
- (4) Females 11.7-16 gm/100ml
- (5) Hematocrit - Males 40-54%, Females 35-47%

If any of these parameters are abnormal, an RBC and indices shall be done. Normal indices are:

|            |                     |
|------------|---------------------|
| RBC- Males | 4.3 to 6.2 million  |
| Females    | 3.8 to 5.4 million  |
| MCV-       | 82-92 cubic microns |
| MCH-       | 27-32 picograms     |
| MCHC -     | 30-36%              |

- (6) Cholesterol Testing. All cadets, officer candidates, and recruits shall be tested for serum cholesterol within a week of their arrival for training. Those persons judged by a medical officer to have cholesterol levels that indicate an increased risk of atherosclerotic vascular disease shall be informed of this and given appropriate counseling by the third week of their training. Lipid panel studies, pharmacological remedial measures, or follow-up appointments may be performed at the discretion of the managing medical officer.
- (7) Serological Test for Syphilis (RPR/STS).
  - (a) Required for entry into the Coast Guard and for all aviation and diving candidate physicals.
  - (b) Unless there is a documented history of adequately treated syphilis, all examinees testing positive shall have repeat testing three or more days later. Ensure that at the time of obtaining serum the examinee neither has, nor is convalescing from, any acute infectious disease or recent fever. If available at no charge, the facilities of local or state health departments may be used for performing serological tests. Examinees with a history of treated syphilis should have declining or low titer positive reaction.
  - (c) If the second test is positive then obtain an FTA/ABS. If the FTA/ABS is positive, further evaluation may be required to determine the appropriate therapy.



- (d) Several conditions that are known to give false RPR/STS are infectious mononucleosis, malaria, yaws, pinta, chicken pox, infectious hepatitis, immunization, and atypical pneumonia. The cause of a false positive serological test for syphilis should be explored since many diseases giving a false positive are also disqualifying.
- (e) Process all members who are suspected contacts or who have clinical evidence of venereal disease and all personnel with a positive serological test for syphilis in accordance with section 7-B-3 of this Manual.
- (8) Sick Cell Preparation Test. Applicants for aviation and diving training shall be tested for sickling phenomenon, if not previously tested. Evaluate positive sickledex results by a quantitative hemoglobin electrophoresis. Greater than 40 percent Hbs is disqualifying for aviation and diving. Once the test has been completed, the results will be filed in the health record and recorded on the Problem Summary List. The test need never be repeated.
- (9) HIV Antibody.
  - (a) The most recent HIV antibody test date will be recorded in item #42 of the SF-88 (Report of Medical Examination), on the NAVMED6150/20 (Problem Summary List), and under Remarks on the SF-601 (Immunization Record). Epidemiological information concerning HIV infection will be monitored by Commandant (G-WKH) and the policy concerning routine testing will be revised as necessary.
  - (b) HIV antibody testing is required as follows (see COMDTINST. 6220.1A):
    - 1 All applicants for regular or reserve programs for enlistment, appointment, or entry on active duty;
    - 2 Candidates for officer service (direct commission, OCS, Academy, MORE, etc.,) as part of pre-appointment or pre-contract physical examination;
    - 3 Cadets at the Coast Guard Academy as part of the physical examination prior to commissioning;
    - 4 All Coast Guard members who have not had at least one documented HIV antibody test in the last four years;
    - 5 All members with PCS orders to a foreign country, within six months prior to transfer;
    - 6 During the clinical evaluation of the patients at high risk of HIV infection being seen for other sexually transmitted diseases or as part of prenatal examinations; and



- 7 Patients being referred to Level II/III alcohol/drug treatment programs must be tested for HIV immediately prior to entering such a program.
- (c) Accession testing will usually be performed through MEPS examination centers. Other required testing can be done through DOD MTFs or designated Coast Guard HIV Antibody Testing Centers. Other required testing will be done through designated Coast Guard-wide HIV contract laboratory, Viomed laboratories. Commanding Officers may arrange testing with the laboratory directors at local uniformed services medical facilities (USMTFS) or qualified local civilian laboratories, only with the permission of, and prior coordination with, MLC(k). Record keeping and reporting requirements must be met. Liaison with the Department of Defense indicates that there are no prohibitions to testing Coast Guard personnel at these facilities. Contact Commander, MLC(k) for permission to use USMTFS or local civilian facilities to arrange methods for reporting results.
  - (d) Members who are confirmed HIV antibody positive or indeterminate by Western Blot, by the Coast Guard-wide contract laboratory, will have a second confirmatory specimen drawn and submitted for analysis to the same Coast Guard-wide contract laboratory. Refer to the COMDTINST 6220.10 for proper handling instructions before submitting the second confirmatory specimen.
  - (e) Members who are confirmed HIV antibody positive by the second confirmatory Western Blot, by the Coast Guard-wide contract laboratory, will be referred to a DOD MTF with the capability to perform a complete evaluation. Contact the respective MLC (k), and they will assist in making arrangements for the evaluation. Ensure that both the medical and dental records accompany the member to the DOD MTF for the evaluation. This evaluation will serve as the basis for an Initial Medical Board, that will be forwarded immediately to Commander (CGPC) (see COMDTINST. 6220.10). Initiate a Disease Alert Report IAW Chapter seven of this Manual.
  - (f) Once a member has been confirmed HIV positive, arrange immediate medical and social services counseling, using available Coast Guard, DOD, or civilian resources to ensure that the member understands the clinical implications of the positive test, the purpose of subsequent medical evaluation, and the policies in this instruction.
  - (g) Members who are confirmed HIV antibody positive shall receive counseling. The individual's command will provide medical and supportive counseling to the member if this has not already been provided by the evaluating facility.



- (h) All information surrounding the individual's physical condition is strictly confidential. Only key personnel, with a verifiable "need to know" such as the individual's commanding officer, should be informed of the HIV status.
- (i) Coast Guard medical officers requiring HIV antibody testing for clinical diagnosis should direct the Coast Guard HIV Antibody Testing Center to send a shipment to the Coast Guard-wide contract laboratory immediately. Results should ordinarily be available within 48 hours via electronic mail or telephone from Commandant (G-WKH).
- (j) HIV antibody testing required by members of other uniformed services (active duty or reserve), or by specific agreement with other Federal agencies (e.g., Department of State), must be performed through a Coast Guard HIV Antibody Testing Center.
- (k) Voluntary testing and counseling of dependents, retirees, and civilian employees must be performed through a Coast Guard HIV Antibody Testing Center.
- (l) Reportable Disease Data Base (RDDDB). All HIV antibody test results performed on Coast Guard members must be entered into the RDDDB. Procedures are already in place for direct entry of test dates into the RDDDB from specimens processed through MEPS, DOD MTFs and Coast Guard HIV Antibody Testing Centers. Dates of all ELISAs performed at local civilian laboratories should be submitted directly to Commandant (G-WKH) for entry into the RDDDB.

c. Chest X-ray.

- (1) Will be accomplished as part of the physical examinations for application for aviation or diving programs. Chest X-rays previously performed within eighteen (18) months of application, with normal results, are acceptable if there is no change in clinical presentation.
- (2) Will not be performed for routine screening purposes without a prior clinical evaluation and a specific medical indication. The senior medical officer may authorize an exception to this policy when there are obvious medical benefits to be gained by routine screening x-ray examination (e.g., Asbestos Medical Surveillance Program). Such exceptions should be authorized only after careful consideration of the diagnostic yield and radiation risk of the x-ray study, as well as other significant or relevant costs or social factors. X-ray examinations will not be ordered solely for medical-legal reasons.

d. Electrocardiogram.

- (1) Electrocardiograms (ECG) shall be accomplished routinely on the following individuals:



- (a) those in whom medical history or clinical findings are suggestive of cardiac abnormalities;
  - (b) examinees with a sitting pulse rate of less than 50 or more than 100;
  - (c) examinees who are 40 years old or older;
  - (d) applicants for aviation and diving training and all designated personnel every four (4) years until age 40, then biennially. For designated aviation personnel on physical examinations where no EKG is required, place the date and results of the last EKG in block #19-d of SF-88; and
  - (e) applicants for service academies.
- (2) All student and designated aviation personnel shall have an ECG on file in their health record.
  - (3) All tracings will be compared to the baseline reading in the health record, if one is present. If significant changes are present, obtain a cardiac consultation. A report of the consult shall be submitted for review along with the SF-88. It is imperative then that proper techniques for recording the ECG be followed.
    - (a) The routine ECG will consist of 12 leads, namely standard leads 1, 2, 3, AVR, AVL, AVF, and the standard precordial leads V1 through V6.
    - (b) Take care to properly place the precordial electrodes. It is important that the electrodes across the left precordium are not carried along the curve of the rib but are maintained in a straight line. Be particular in placing the first precordial lead so as to avoid beginning placement in the third interspace rather than the fourth. Do not smear electrode paste from one precordial position to another. Include a standardization mark on each recording.
- e. Urinalysis. A urinalysis is required on all physical examinations. The urine shall be tested for specific gravity, glucose, protein, blood, leukocyte esterase, and nitrite by an appropriate dipstick method. A microscopic examination is required only if any of these dipstick tests is abnormal.
- (1) Specific Gravity. Normal values are 1.005-1.035. Specific gravity varies with fluid intake, time of day, climate, and medication. As a rule, elevation of the specific gravity reflects only the state of hydration, while a low specific gravity may reflect kidney disease. In evaluating abnormalities, a repeat is generally sufficient, provided the factors above are considered and explained to the individual. Where possible, the repeat should be a first morning specimen which is usually the most concentrated.
  - (2) Glucose. Any positive test is abnormal. A false positive for glucose may occur in individuals who take Vitamin C or drink large quantities of fruit juice. As soon as practical after discovery of the glycosuria, obtain a fasting blood



glucose. If glycosuria persists or if the fasting blood glucose exceeds 125 mg/100 ml, evaluate the individual for diabetes.

- (3) Protein. A trace positive protein is often associated with a highly concentrated (specific gravity 1.024 or greater) early morning specimen and is considered normal and need not be repeated. A one plus or greater protein, or a trace positive in the presence of a dilute urine, should be evaluated by a 24-hour specimen (normal range 10-200 mg protein/24 hours).

- (4) Microscopic.

- (a) Normal: 0-5 WBC

0-5 RBC (clean catch specimen)

occasional epithelial cells (more may be normal  
in an otherwise normal urinalysis)

no casts occasional bacteria

- (b) Pyuria usually indicates an infection or improper collection techniques. Appropriate follow-up is required, including repeat after the infection has cleared.
    - (c) Hematuria may normally occur following heavy exercise or local trauma and as a false positive in menstruating females. It always requires evaluation with the minimum being a repeat showing no hematuria.
    - (d) Casts, heavy bacteria, other organisms, and abnormal cells require further evaluation.

f. PAP Test.

- (1) A PAP test is required at the following times on female members:
  - (a) on the pre-training physical examination at time of initial entry into the Coast Guard;
  - (b) every two years, if on extended active duty; and
  - (c) with quinquennial examinations, for reserves.



- (2) PAP tests and pelvic examinations (by civilian or military practitioners) that have been performed within one year of periodic examinations are acceptable. In any case, results of the pelvic examination and PAP test will be recorded in Items 19-F and/or 42, as appropriate. The practitioner is responsible for communicating the result of the PAP smear (either positive or negative) to the patient.
  - (3) To reduce false-negative smears, endocervical sampling shall be done using a cytobrush, provided no contraindication is present (as in pregnancy or cervical stenosis). Laboratories to which smears are sent for interpretation must, as a matter of routine, indicate on their reports whether endocervical sampling was adequate. Where endocervical cell sampling is reported as inadequate, the smear shall be repeated.
- g. Pulmonary Function Test (PFT). Perform a PFT on all OMSEP examinations and when clinically indicated.
- (1) Screening spirometry should not be performed if the subject:
    - (a) is acutely ill from any cause;
    - (b) has smoked or used an aerosolized bronchodilator within the past hour;
    - (c) has eaten a heavy meal within the previous two hours; or
    - (d) has experienced an upper or lower respiratory tract infection during the past three weeks.
  - (2) Explain the procedure to the subject.
  - (3) Instruct the subject to remove any tight clothing or dentures and to sit or stand comfortably in front of the spirometer. The chin should be slightly elevated with the neck slightly extended. The use of a nose clip is recommended.
  - (4) Tell the subject to take the deepest possible inspiration, close mouth firmly around the mouthpiece and without further hesitation, blow into the apparatus as hard, fast, and completely as possible. Active coaching throughout the entire duration of the forced expiration must be done to elicit maximum subject effort. Positioning of the lips around the mouthpiece should be checked.
  - (5) After two practice attempts, three further tracings should be recorded. If the technician believes that the subject has not made a full inspiration prior to the forced expiration, not put forth a maximal effort, or not continued expiration sufficiently long, that particular tracing should be repeated. Repeat attempts marred by coughing. The variation between the largest and smallest FVC of three satisfactory tracings should not exceed 10%.
  - (6) From the three satisfactory tracings, the FVC, FEV<sub>1</sub>, and FEV<sub>1</sub>/FVC% should be determined. Use the highest FVC and FEV<sub>1</sub> in the calculations regardless of the curve(s) on which they occur. The tracing itself should also be maintained as part of the medical record.



- (7) If the tests are baseline studies, determine the predicted values and calculate the subject's percent of the predicted normal, and transcribe results on the record sheet. In non-Caucasians, the predicted FEV<sub>1</sub> and FVC should be multiplied by 0.85 to adjust for ethnic differences. No correction factor is necessary for the FEV<sub>1</sub>/FVC%.
- (8) If the tests are follow-up studies, comparison should be made with the previously recorded highest value for each test. This highest value may not necessarily have occurred during baseline tests.
- (9) Verify any abnormalities in either baseline or follow-up pulmonary functions by repeating spirometry in two weeks. If abnormalities persist, clinical assessment by a physician qualified to evaluate chest disease is essential. In males, a 30 millimeter annual decline in FEV<sub>1</sub> and 25 millimeters FVC can be attributed to normal aging. In females, it is 25 millimeters in both the FEV<sub>1</sub> and FVC. PFT. Abnormal functions are present when:
  - (a) FEV-1 or FVC is less than 80% of predicted;
  - (b) FEV-1/FVC% is less than 69%;
  - (c) decline in the FEV-1 or FVC greater than 8%;
  - (d) decrease in the FEV-1/FVC% greater than 6%; and
  - (e) see the following:

### SPIROMETRIC GUIDELINES

|                         | OBSTRUCTIVE DISEASE | RESTRICTIVE<br>DISEASE FVC%<br>FVC PREDICTED |
|-------------------------|---------------------|--|
|                         | FEV-1/FVC           |  |
| <b>NORMAL</b>           | > 0.69              | > .80  |
| <b>MILD TO MODERATE</b> | 0.45 -0.69          | 0.51-0.80                                    |
| <b>SEVERE</b>           | < 0.45              | <0.51  |

- h. Special Tests. In some cases, information available should be supplemented by additional tests or diagnostic procedures (eye refractions, x-rays, repeated blood pressure readings, etc.), in order to resolve doubts as to whether the examinee is or is not physically qualified. If facilities are available to perform such tests at no cost, they should be obtained as indicated in individual cases. Otherwise, applicants for



original entry in the Service will be required to obtain such tests at their own expense, if they desire further consideration.

- i. Laboratory Values (OMSEP). All laboratory values not previously discussed but that accompany a physical examination (e.g., chemistry profiles, etc.) must have accompanying normals for the laboratory that performed the tests.
  - j. Mammography. Mammography is required for Coast Guard active duty and reserve females beginning at age 40 and at ages 44, 48, 50, 52, 54, 56, 58, 60, and 62. Clinical findings, family history, and other risk factors may dictate that a mammogram be done at times other than those indicated in this screening schedule. Results should be documented on the routine physical exams. Mammograms done between the required screening ages can be used to satisfy the periodic requirement. This judgment is left to the practitioner. If mammography is not done at the required ages, the reason must be supplied in item 42 of the SF 88 and should include date and result of the last mammogram. Practitioners are responsible for communicating mammography results (either positive or negative) to the patient.
  - k. Glucose-6-Phosphate Dehydrogenase (G-6-PD). Qualitative testing (present or not) for G-6-PD deficiency is required at all accession points (TRACEN Cape May, Academy, RTC Yorktown). All other Coast Guard members with no record of testing shall be tested prior to assignments afloat or to malaria-endemic areas. The results of testing shall be annotated on the Problem Summary List. Once testing is accomplished, it need never be repeated.
21. Height, Weight, and Body Build (Items 20, 21 and 24 of SF-88).
- a. Height. Measure the examinee's height in centimeters (inch) to the nearest centimeter (one-half inch), without shoes.
  - b. Weight.
    - (1) Weights are with underwear/undergarments only.
    - (2) Weigh the examinee on a standard set of scales calibrated and accurate. Record the weight to the nearest kilogram (pound). Do not record fractions of kilogram.
  - c. Frame Size. Using a cloth tape, measure the wrist of the dominant hand, measure all the way around from lateral to medial styloid process. Measure in centimeters (fraction of an inch).
  - d. Body Fat Percentage. Determined by MEPS.
22. Distant Visual Acuity and Other Eye Tests (Items 28 through 30 of SF-88).
- a. Distant Visual Acuity, General. Visual defects are one of the major causes for physical disqualification from the armed services. Methods of testing vision have varied greatly among the armed services and from place to place in each Service. Consequently, visual test results are not always comparable. An examinee



presenting for examination at one place might be qualified for visual acuity, while at another place, disqualified. Although this is an undesirable situation, no practical solution, such as prescribing standards for equipment and conditions (room size, ventilation, paint colors, room illumination, etc.), is available to the Coast Guard as the examinations are obtained from various sources over which the Coast Guard has no control. It is therefore imperative that examiners be especially painstaking to obtain the most accurate results possible.

b. Examination Precautions.

- (1) Make every effort to conduct the examination when the examinee is in normal physical condition. Follow the examination routine in the order prescribed in the following instructions. Record the vision for each eye when determined so that errors and omissions will be avoided.
- (2) It may be extremely difficult to obtain an accurate measure of visual acuity. Bear in mind that individuals who are anxious to pass visual acuity tests may resort to deception. Similarly, other individuals may attempt to fail a visual acuity test to avoid undesirable duties. Hence, be prepared to cope with either possibility in order to uncover and recognize visual defects without the cooperation of the person being tested.
- (3) Refer uncooperative examinees to a medical officer.

c. Examination Procedures.

- (1) In order to obtain a more valid evaluation, inform examinees that contact lenses will not be worn during the evaluation and for 72 hours before. Orthokeratotic lenses shall be removed for 14 days or until vision has stabilized for 3 successive examinations.
- (2) If the examinee wears glasses, they must be removed before entering the exam room. Test each examinee without unnecessary delay after entering the examining room. In order to prevent personnel from memorizing the charts, permit only one examinee to view the test charts at a time. Keep examinees awaiting testing out of hearing.
- (3) Direct the examinee to a line that is 20 feet from the test chart. Hold an occluder so that it covers the examinee's left eye. Instruct the examinee to keep both eyes open and not to squint. The occluder must not be pressed against the eyeball or lids or any part of the eye being shielded, but, should be held in contact with the side of the nose. The eye shielded by the occluder should be left open in order to avoid pressure and to discourage squinting. A rigid occluder, constructed of a material such as wood, translucent plastic, or metal, of a design to discourage cheating shall be used to shield the eye not being tested.
- (4) Direct the examinee to begin with the first line and to read as many lines as possible. (Watch the examinee, not the chart that is being read. Hold the occluder so the examinee cannot peep around it. The most frequently used method of increasing visual acuity is to squint. This will not be permitted.



Some examinees with astigmatism will be able to read the letters better by tilting the head to one side; do not allow this. Another well-known method used to pass a visual acuity test is to obtain eyedrops beforehand that contract the pupil; suspect this if the pupils are unusually small.)

- (5) Record the smallest line read with no errors on the chart from the 20 foot distance as the vision for the right eye (O.D.).
  - (6) Test the visual acuity for the left eye (O.S.), preferably using a different chart, record in the same manner.
  - (7) Test the visual acuity for both eyes (O.U.), preferably with a third chart, record in the same manner.
  - (8) Test an examinee who wears glasses again with them on. Follow the same procedure as without glasses.
  - (9) When there is suspicion that the examinee has memorized a chart, a different chart should be used or the letters on the chart should be read in reverse order.
  - (10) The examinee is expected to read letters promptly. No precise time limit should be applied, but 1 or 2 seconds per letter is ample.
  - (11) An examinee who fails a letter should not be asked to read it again. If a rapid reader makes an obviously careless mistake, caution the examinee to "slow down" and repeat the test using another chart.
  - (12) Some examinees give up easily. They may need encouragement to do their best; however, do not coach them.
  - (13) The effects of fatigue may make a certain amount of retesting necessary. In questionable cases, one retest should be given not less than the day after the initial test.
- d. Armed Forces Vision Tester (AFVT). Visual acuity may also be determined with the (AFVT) which consists of two rotating drums holding illuminated slides for testing various facets of vision. The examinee observes the distance slides looking slightly downward with the instrument set and also observes the near slides looking downward at a greater angle. The handles on the side of the instrument rotate the drums to change the slides. Beneath the eye pieces there is a lever that operates an occluder so that each eye can be tested separately. In the case of the slides for muscle balance and stereopsis, the two eyes must be tested together and the occluder should be centered so it occludes neither eye. A scoring key is provided with the instrument. The following slides are available:
- (1) Rear Drum (Distance Testing).
    - (a) Slide 1 - Vertical Phorias.
      - 1 The right eye sees a set of numbered steps, the left sees a dotted line. With both eyes open the examinee is asked which step the dotted line intersects. Interpretation: step 1, 2 prism diopters of left hyperphoria; step 2, 1.5 left hyperphoria; step 3, 1.0 left



hyperphoria; step 4, 0.5 left hyperphoria; step 5, orthophoria; step 6, 0.5 prism diopters of right hyperphoria; step 7, 1.0 right hyperphoria; step 8, 1.5 right hyperphoria; step 9, 2.0 right hyperphoria.

- 2 Detecting Malingerers: i.e., if known that a score of 5 is normal, the examinee could feign a normal phoria. To avoid this, a pair of VARIABLE PRISMS is provided, by which the examiner can raise either the right or the left eye image. The prisms are mounted within the viewing box. The extent of prismatic deviation is governed by the position of two control handles.
  - 3 The correct score--and the only score recorded--is that obtained when both control handles of the VARIABLE PRISM are pushed inward as far as they will go. This is known as the SCORING POSITION. Moving the left handle outward from this position moves the left eye image downward and outward. Similarly, moving the right handle outward moves the right eye image downward and outward.
  - 4 The maximum amount of downward shift provided by each control corresponds to four steps. Moving the right handle outward to its extreme position therefore will change the apparent location of the dotted line from step 1 to step 5, for example, from 6 to above 9, etc. Moving the left control handle outward to its extreme position similarly will change the apparent location of the dotted line from step 5 to step 1, or from step 8 to step 4, etc. Vary the location of the right or left control handle, each time asking the examinee to report the location of the dotted line. Only the answer obtained when both handles are in the SCORING POSITION gives the examinee's test score.
- (b) Slide 2 - Horizontal Phorias.

- 1 The examinee's right eye sees a row of numbered dots, the left eye sees an arrow, with the occluder in the open position, ask the examinee to which numbered dot the arrow is pointing.  
Interpretation: The reporting value minus 11 equals prism diopters of exophoria; 11 minus the reported value equals the prism diopters of esophoria.
- 2 DETECTING MALINGERERS: By means of the VARIABLE PRISM previously mentioned, the right and left eye images can both be shifted outward a maximum of seven dots. To produce this outward shift without a downward shift, in this test both control handles are moved outward simultaneously by the same amount. When both handles are shifted as far out as they go, the apparent



position of the arrow is moved seven dots to the left, giving a score seven below the true score.

3 As in previous test, the correct score and the only score recorded is that obtained when the control handles are in the SCORING POSITION.

- (c) Slides 3 and 3A - Visual Acuity. With both eyes uncovered the examinee sees a jumble of letters. With one eye covered, the uncovered eye cannot see the letters intended for the opposite eye.
- (d) Slides 4 and 4A - Visual Acuity, Large Letters. Separate charts for the left and right eye.
- (e) Slides 5 and 5A - Stereopsis. Six groups of horizontal lines, five circles to a line. The groups are numbered A to F. In each horizontal row of circles, one circle stands out closer to the examinee. The degree of difficulty increases from A to F. The examinee calls the circle that stands out. Passing score: There must be no misses in groups A through D. Caution: Ensure that neither eye is inadvertently left occluded when this test is being given. Both eyes must be able to see the circles in order for any stereopsis to occur.

(2) Front Drum (Near Testing).

- (a) Slide 6 - Vertical Phorias. Same as slide 1, only this is a near test.
- (b) Slide 7 - Horizontal Phorias. Same as slide 2, except subtract 13.
- (c) Slide 8 - Near Visual Acuity. This is given in Snellen notations.
- (d) Slide 9 - Near Visual Acuity, Large Letters.

e. Score recording. Record vision test scores as a fraction in that the upper number is the distance in feet from the chart and the lower number is the value of the smallest test chart line read correctly. Thus, a person reading at a distance of 20 feet, the 30 foot test chart line is given a score of 20/30. 20/20 indicates that a person reads at a distance of 20 feet the test chart line marked 20. Similarly, 20/200 means a person can read at a distance of 20 feet only the test chart line marked 200.

f. Refraction (Item 29 of SF-88).

(1) Eye refractions are required:

- (a) when applying for flight training (SNA) (This must include cycloplegic.); and
- (b) when visual acuity falls below 20/20 in either eye (near or distant).



- (2) Subsequent refractions are required only if the visual acuity deteriorates further.
  - (3) If a cycloplegic is used during the course of refraction, then the examinee must wear dark glasses until the effects disappear. The installation of 1 drop into each eye of 1% solution of pilocarpine hydrochloride in distilled water after completing the examination will constrict the pupil and thus relieve the photophobia.
- g. Near Vision (Item 30 of SF-88). Test near vision on all examinees and record results in Item 61 of SF-88 using Snellen notations. The examinee should be positioned so that the light source is behind him/her and the near vision test card is well illuminated. The examiner shall instruct the examinee to hold the test card exactly 14 inches/35.5 cm in front of their eyes (measure from the inner aspect of the lower eyelid [corner of the eye] to the face of the card to ensure accurate distance). Test each eye separately. Note the smallest line of type that the examinee is able to read with each eye. Record near vision both with and without corrective lenses if glasses are worn or required. Record corrections worn in Item 42. See the chart below for conversion from the various near point letter nomenclatures to Snellen notations.

CONVERSION TABLE FOR VARIOUS NEAR POINT LETTER NOMENCLATURE

| Standard Test Chart | Snellen English Linear | Snellen Metric | Jaegar |
|---------------------|------------------------|----------------|--------|
| 14/14               | 20/20                  | 0.50           | J-1    |
| 14/17.5             | 20/25                  | .62            | J-2    |
| 14/21               | 20/30                  | .75            | J-4    |
| 14/28               | 20/40                  | 1.00           | J-6    |
| 14/35               | 20/50                  | 1.25           | J-8    |
| 14/49               | 20/70                  | 1.75           | J-12   |
| 14/70               | 20/100                 | 2.25           | J-14   |
| 14/140              | 20/200                 |                |        |



h. Heterophoria (Item 31 of SF-88).

- (1) Except for aviation personnel, special tests for heterophoria are not required unless medically indicated.
- (2) Heterophoria is a condition of imperfect muscle balance in which the eyes have a constant tendency to deviate and latent deviation is overcome by muscular effort (fusion to maintain binocular single vision). Fusion is responsible for the two eyes working together in harmony and when anything prevents this, fusion is disrupted and one eye deviates. Since heterophoria is only a tendency of the eyes to deviate, no actual deviation is apparent when the eyes are being used together under ordinary conditions. The deviation becomes visible only when fusion control is weakened or abolished. When deviation occurs, its exact amount can be estimated with some accuracy by neutralizing the deviation with prisms of varying strength. If the eye deviates toward its fellow, the deviation is known as esophoria; if it deviates away from its fellow, the deviation is known as exophoria; if it deviates up or down, the deviation is known as hyperphoria. The condition of perfect muscle balance (no deviation) is orthophoria.
- (3) The vertical and horizontal phorias may be tested with the Phoropter or AFVT.

i. Accommodation (Item 32 of SF-88). There is no requirement to test accommodation unless medically indicated.

j. Color Perception Tests (Item 33 of SF-88). Examinees are qualified if they pass either the Pseudoisochromatic Plates (PIP) or the Farnsworth Lantern (FALANT) test. Examinees may be found qualified "on record" if a previous certified physical examination that has a passing PIP or FALANT score is available for review. Examinees who fail the PIP are qualified if they pass the FALANT.

(1) Farnsworth Lantern Test.

(a) Administration and Scoring.

- 1 Instruct the examinee: "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time--in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors--red, green, and white--and top first."
- 2 Turn the knob at the top of the lantern to change the lights; depress the button in the center of the knob to expose the lights. Maintain regular timing of about two seconds per exposure.



- 3 Expose the lights in random order, starting with RG or GR combinations (Nos. 1 or 5), continuing until each of the 9 combinations have been exposed.
  - 4 If no errors are made on the first run of nine pairs of lights, the examinee passes.
  - 5 If any errors are made on the first run, give two more complete runs. Passing score is at least 16 out of 18 correct for the two runs.
  - 6 An error is considered the miscalling of one or both of a pair of lights; if an examinee changes responses before the next light is presented, record the second response only.
  - 7 If an examinee uses glasses for distance, they shall be worn.
  - 8 If an examinee says "yellow," "pink," etc., state, "There are only 3 colors--red, green, and white."
  - 9 If an examinee takes a long time to respond, state, "As soon as you see the lights call them."
- (b) Operation of Lantern.
- 1 Give the test in a normally lighted room; screen from glare; exclude sunlight. The examinee should face the source of room illumination.
  - 2 Test only one examinee at a time (do not allow others to watch).
  - 3 Station the examinee 8 feet from the lantern.
  - 4 The examinee may stand or sit; tilt the lantern so that the aperture in the face of the lantern is directed at examinee's head.
- (2) Pseudoisochromatic Plates. When Pseudoisochromatic Plates are used to determine color perception, a color vision test lamp with a daylight filter or a fluorescent light with a daylight tube shall be used for illumination. Do not allow the examinee to trace the patterns or otherwise touch test plates. Show the plates at a distance of 30 inches and allow 2 seconds to identify each plate. If the examinee hesitates, state "read the numbers." If the examinee fails to respond, turn to the next plate without comment. Qualification is ascertained as follows:
- (a) 20 plate test set. Examinee must correctly read at least 17, excluding demonstration plates.
  - (b) 18 plate test set. Examinee must correctly read at least 14, excluding demonstration plates.



- (c) 15 plate test set. Examinee must correctly read 10 plates.
- k. Depth Perception (Item 34 of SF-88). Required for all aviation personnel and when medically indicated. The AFVT is the most commonly used method of testing depth perception. When this instrument is not available or the examinee fails the AFVT, use a TITMUS or Verhoeff Stereopter. Results obtained with the TITMUS or Verhoeff are final in resolving all cases of questionable depth perception.
  - (1) Findings.
    - (a) AFVT. An error in group A, B, C, or D is disqualifying.
    - (b) Verhoeff. Failure to correctly report eight out of eight in two of three trials is disqualifying.
    - (c) ITMUS Vision Screener. "requirements being developed"
  - (2) Operating the Verhoeff.
    - (a) As a preliminary, show target #2 (the second target down when the instrument is upright) at about 40 centimeters and bring it nearer if necessary. This will acquaint the examinee with what is to be observed and at the same time determine whether there is at least a distance, however short, that can be judged correctly.
    - (b) Show one or two positions at close range to the examinee to clearly demonstrate that one rod is always at difference from the other two. Point out that the size of the rods is not a clue to the relative distance. The examinee is now ready for the test.
    - (c) Hold the apparatus 1 meter from the examinee.
    - (d) Eight different rod relations are possible and all eight are shown.
    - (e) Keep the device centered as a frontal plane normal to the subject's binocular visual midline. To avoid helpful extraneous cues it is highly important to hold the device steady, and particularly not to rotate it on its vertical axis. It is also important not to permit the subject to move the head.
    - (f) Do not expose the target window while the device is being placed in position or the sets are changed. A convenient method of manipulation is to grasp the device over the target window with the left hand, place the desired set into position with the right hand, then grasp the device below with the right hand and expose the target window by moving the left hand up or down. Thus while the target window is exposed, the device is supported by both hands of the examiner.



- (g) The instructions to the subject are: "Report the nearest strip and the farthest strip, unless they all appear to be at the same distance, referring to the strips as 'left,' 'middle,' and 'right'." Only the report concerning the one strip out of plane (farther or nearer than the other two that are in the same plane) is to be considered.

l. Field of Vision (Item 35 of SF-88).

- (1) Except for aviation personnel, special tests for field of vision are not required unless medically indicated.
- (2) Procedure.
  - (a) Face the examinee at a distance of 2 feet.
  - (b) Close right eye and instruct the examinee to close left eye and focus right eye on your left eye.
  - (c) Bring fingers in from the periphery, midway between you and the examinee.
  - (d) Instruct the examinee to say when and how many fingers seen.
  - (e) Test all cardinal points.
  - (f) Repeat test for the left eye.
  - (g) Any evidence of abnormality should be given study on the perimeter.
- (3) Normals.
  - (a) Temporally -  $90^{\circ}$ .
  - (b) Superotemporally -  $62^{\circ}$ .
  - (c) Superiorly -  $52^{\circ}$ .
  - (d) Superonasally -  $60^{\circ}$ .
  - (e) Inferonasally -  $55^{\circ}$ .
  - (f) Inferiorly -  $70^{\circ}$ .
  - (g) Inferotemporally -  $85^{\circ}$ .

- m. Night Vision (Item 36 of SF-88). A test for night vision (dark adaptation) is not required unless indicated for medical or special reasons.



n. Red Lens Test (Item 37 of SF-88). The red lens test is required on DODMERB examinations and when medically indicated.

- (1) Apparatus. A spectacle trial frame, a red lens from the trial lens case, a small light such as a muscle balance light, and a metric rule or tape.
- (2) Procedure.
  - (a) Seat the examinee in the darkness facing the dark wall or tangent curtain at 75 cm distance.
  - (b) Adjust the spectacle trial frame position and place the red lens in one cell of the trial frame.
  - (c) With the examinee's head in a fixed position, hold the small lamp directly before the center of the dark wall or tangent curtain at 75 cm distance from the eyes. Note the presence or absence of diplopia in this position (primary).
  - (d) Then slowly move the light from the central position toward the right for a distance of 50 cm in the horizontal plane. In the same manner, move the light in the remaining five cardinal directions.
  - (e) In the presence of diplopia, note whether it is crossed, homonymous, or vertical and the distance in centimeters from the central position at which diplopia first occurs.
  - (f) When diplopia is suspected and the examinee has been coached to deny its presence, a prism of 3 or 4 diopters may be placed, either base up or base down, in one cell of the trial frame. If diplopia is still denied, the statement is obviously untrue.
- (3) Precautions. The examinee's head must remain fixed and the movement of the light followed only by the eyes. Do not permit tilting or rotating the face.

o. Intraocular Tension (Item 38 of SF-88).

- (1) General. Determine intraocular tension each time an eye refraction is performed, during all annual physical examinations, all aviation physicals, and when medically indicated. Above normal tension is a sign of glaucoma; below normal tension of ten exists in degenerated eyeballs or as a normal finding; alterations in tension are sometimes found in cyclitis. Questionable findings on palpation and ophthalmoscopic examination shall be further evaluated.
- (2) Testing Intraocular Tension.
  - (a) General. Routine tonometry shall be performed by a medical officer, optometrist, or a technician who has received instruction in properly performing and interpreting this test.



- (b) Instrument. The tonometer estimates the intraocular pressure (IOP) or tension within the eyeball.
- (c) Precaution. Determine intraocular tension after all other eye examinations have been completed. Because of corneal denuding by tonometric measurement, a refraction (cycloplegic or manifest) shall not be performed for at least 24 hours following this procedure.
- (d) Readings. Intraocular pressure consistently above 25 mm Hg in either eye or a difference of 4 or more between the two eyes, shall be referred for ophthalmologic evaluation.

23. Audiometer (Item 40 of SF-88).

- a. An audiometric examination is required on all physical examinations using frequencies 500, 1000, 2000, 3000, 4000, and 6000 hertz.
- b. Obtain reference audiograms on all personnel upon initial entry into the Coast Guard at recruit training and all officer accession points (Academy, OCS, Direct Commission, etc.), and at first duty station for all others.

24. Psychological and Psychomotor (Item 41 of SF-88). Psychological and psychomotor testing is not required unless medically indicated.



FIGURE 3-C-1

The following chart enumerates certain conditions, defects, and items of personal history that require thorough evaluation and sets forth the special test, examination, or report desired in each instance.

| ITEM:   | EXAMINATION AND INFORMATION DESIRED:   |
|---|--|
| ALBUMINURIA, findings of  | Repeat test on a second specimen. If still positive do a quantitative 24 hr urine protein.   |
| ASTHMA history of,  | Detailed report of asthma and other allergic conditions and a statement from cognizant physician on (1) number and approximate dates of attacks of asthmatic bronchitis or other allergic manifestations; (2) signs, symptoms, and duration of each attack; (3) type and amount of bronchodilating drugs used, and history of any attacks requiring hospitalization. |
| BACKACHE, back injury or wearing of back strength,                        | Current orthopedic consultation and report on stability, mobility, and functional brace, history of capacity of back. Report of appropriate x-rays. Transcript of any treatment from cognizant physician.  |
| BLOOD PRESSURE, elevated  | Repeat blood pressure (all positions) a.m. and p.m. for 3 consecutive days. Prolonged bed rest shall not precede blood pressure determinations.  |
| CONCUSSIONS   | See Head Injury  |
| CONVULSIONS OR SEIZURE  | Neurological consultation and electroencephalogram. Transcript of any treatment from cognizant physician.  |
| DIABETES, family history of parent, sibling, or more than one grandparent | Fasting glucose (normal diet with 10-12 but less than 16 hours fast). If elevated, repeat and include 2 hr post prandial.  |
| DIZZINESS or FAINTING SPELLS, history of                                  | Neurological consultation  |
| ENURESIS or history of into late childhood or adolescence (age 12)        | Comment on applicant's affirmative reply to question "bed wetting" to include number of past incidents and age at last episode.  |
| FLATFOOT, symptomatic   | Current orthopedic consultation with history. Detailed report on strength, stability, mobility, and functional capacity of foot. Report of appropriate x-rays.   |
| GLYCOSURIA, finding or history  | See Diabetes.  |
| HAY FEVER, history of   | Detailed report of hay fever and other allergic conditions and a statement from personal physician on (1) number, severity, and duration of attacks of hay fever or any other allergic manifestations, and (2) type and amount of drugs used in treatment thereof.   |
| HEADACHES, frequent or severe, history of                                 | Neurological consultation.   |



### FIGURE 3-C-1

|  |   |
|--|---|
| HEAD INJURY with loss of consciousness in past 5 years, history of HEMATURIA, history of or finding of | Neurological consultation; clinical abstract of treatment from physician.<br><br>Medical consultation with evaluation report, including appropriate laboratory studies and/or complete urological evaluation if indicated.  |
| HEPATITIS, history of  | Serum Bilirubin, SGOT, SGPT, SGT, Anti-HCV, and HB <sub>s</sub> Ag.   |
| JAUNDICE, history of in past 5 years   | Serum Bilirubin, SGOT, SGPT, and SGT.   |
| JOINT, KNEE, internal derangement, history of  | Current orthopedic consultation and report of strength, stability, mobility, and functional capacity of knee. Report of appropriate x-rays together with comparative measurement of the thighs, knees, and legs.  |
| JOINT, SHOULDER, dislocation, history of   | Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of shoulder. Report of appropriate x-rays.   |
| MALOCCLUSION, TEETH, history of  | Report of examination by a dentist with comment as to whether incisal and masticatory function is sufficient for satisfactory ingestion of the ordinary diet, statement as to presence and degree of facial deformity with jaw in natural position and clarity of speech. |
| MASTOIDECTOMY, bilateral, history of audiogram.  | Current ENT consultation to include   |
| MOTION SICKNESS, history of  | Detailed report of all occurrences of motion sickness (such as air, train, sea, swing, carnival-ride), and the age at the time of the last occurrence.  |
| NASAL POLYPS, history of   | ENT consultation, with comment as to date polyps removed if no longer present. Detailed report by physician on allergic history and manifestation to include required medication.   |
| SKULL FRACTURE, in past 5 years, history of  | See Head Injury.  |
| SLEEPWALKING, beyond childhood, history of (age 12)  | Detailed comment by physician. Comment on applicant's affirmative reply to question "been a sleepwalker" to include number of incidents and age at last episode.  |
| SQUINT (cross eyed) Examination  | for degree of strabismus and presence of complete and continuous 3rd degree binocular fusion. Request completion of SF-88 Items 62 and 65 and notation of degree of strabismus.   |
| STUTTERING or STAMMERING,  | Report of Reading Aloud Test in Section 3-C-2.  |
| VERTEBRA, fracture or dislocation, history of  | Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of spine. Report of appropriate x-rays.  |



FIGURE 3-C-3

| HEIGHT STANDARDS  |                     |                     |
|---|---------------------|---------------------|
| Category  | Minimum (cm/inches) | Maximum (cm/inches) |
| <b>AVIATION PERSONNEL:</b>  |                     |                     |
| Candidate for Flight Training   | 157.4/62            | 198/78              |
| Class 1 Pilot   | 157.4/62            | 198/78              |
| Designated Flight Officer   | 157.4/62            | 198/78              |
| Aircrew Candidate   | 152.5/60            | 198/78              |
| Designated Aircrew  | 152.5/60            | 198/78              |
| <b>ENLISTED PERSONNEL:</b>  |                     |                     |
| Enlistment in USCG  | 152.5/60            | 198/78*             |
| Enlistment in USCG Reserve  | 152.5/60            | 198/78*             |
| <b>CANDIDATES FOR:</b>  |                     |                     |
| USCG Academy  | 152.5/60            | 198/78*             |
| Officer Candidate School  | 152.5/60            | 198/78*             |
| Appointment of Licensed Officers of U.S. Merchant Marines in the USCG | <u>152.5/60</u>     | <u>198/78*</u>      |
| Direct Commission in USCG   | 152.5/60            | 198/78*             |

- MAXIMUM HEIGHTS WAIVERABLE TO 203 CM/ 80 INCHES BY COMMANDER COAST PERSONNEL COMMAND (CGPC-adm-1)

NOTES:

1. Heights are without shoes.
2. Metric conversion: 1 inch = 2.54 cm



FIGURE 3-C-4

## MINIMUM DISTANT VISUAL ACUITY REQUIREMENTS

| CATEGORY  | VISION             |                  |
|---|--------------------|------------------|
| A. <u>Aviation Personnel</u> :  | <u>Uncorrected</u> | <u>Corrected</u> |
| 1. Candidates for Flight Training   | 20/50              | 20/20            |
| 2. Pilot, Class   | 20/200             | 20/20            |
| 3. Pilot, Class 1R  | (as waived)        | 20/20            |
| 4. Designated Flight Officer  | 20/400             | 20/20            |
| 5. Flight Surgeon,<br>Aviation Medical Examiner or<br>Aviation MEDEVAC Specialist | 20/400             | 20/20            |
| 6. Candidate for Aircrew  | 20/100             | 20/20            |
| 7. Designated Aircrew   | 20/200             | 20/20            |
| 8. Landing Signal Officer (LSO)   | 20/200             | 20/20            |
| 9. Air Traffic Controller Candidate   | 20/100             | 20/20            |
| 10. Designated Air Traffic Controller   | 20/200             | 20/20            |
| B. <u>Officers</u> (Note 1):  |                    |                  |
| 1. Commissioned or Warrant in the USCG<br>or USCGR                                | 20/400             | 20/20            |
| 2. Appointment in the USCG of Licensed<br>Officers of the Merchant Marine         | 20/400             | 20/20            |
| 3. Direct Commission in the USCGR   | 20/400             | 20/20            |
| 4. Appointment as Cadet   | 20/400             | 20/20            |
| 5. Precommissioning of Cadets   | 20/400             | 20/20            |
| 6. OCS Candidates   | 20/400             | 20/20            |
| 7. Precommissioning of Officer Candidates   | 20/400             | 20/20            |
| 8. Diving Candidates  | 20/100             | 20/20            |
| 9. Designated Diver   | 20/200             | 20/20            |
| C. <u>Enlisted Personnel</u> :  |                    |                  |
| 1. Enlistment in the USCG or USCGR  | See 3.D.13.a       | (Note 2)         |
| 2. Diving Candidates  | (Note 3)           | 20/20            |
| 3. Designated Diver   | (Note 3)           | 20/20            |

Notes:

1. Refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder) and that astigmatism does not exceed 3.00 diopters and anisometropia does not exceed 3.50 diopters.
2. Corrected vision shall be 20/40 in the better eye and 20/70 in the other or 20/30 in the better eye and 20/100 in the other, or 20/20 in the better and 20/400 in the other. (Note that near visual acuity must correct to at least 20/40 in the better eye.) Refractive error does not exceed plus or minus 8.00 diopters spherical equivalent (sphere + 1/2 cylinder) and ordinary spectacles do not cause discomfort by reason of ghost images, prismatic displacement, etc.; error must not have been corrected by orthokeratology or keratorefractive surgery.
3. 20/100 in the better eye and 20/200 in the worse eye.



## Section D Physical Standards for Enlistment, Appointment, and Induction

1. Scope. This section implements Department of Defense (DOD) Directive 6130.4 "Physical Standards for Enlistment, Appointment, and Induction," December 14, 2000, which established physical standards for enlistment, appointment, and induction into the Armed Forces of the United States in accordance with section 115, title 10, United States Code (10 USC 133), and by agreement with Secretary, DOT applies to USCG. It is Coast Guard policy to conform, to the maximum extent possible, to common physical standards for the acquisition of personnel among all the Armed Forces.
2. Applicability and Responsibilities.
  - a. Applicability.
    - (1) This section sets forth the medical conditions and physical defects which are causes for rejection for military service. Those individuals found medically qualified based on the medical standards in effect prior to this regulation will not be reevaluated or medically disqualified solely on the basis of the new standards.
    - (2) The standards of this section apply to:
      - (a) Applicants for enlistment in the Regular Coast Guard. For medical conditions or physical defects predating original enlistment, these standards are applicable for enlistees' first 6 months of active duty.
      - (b) Applicants for enlistment in the Coast Guard Reserve. For medical conditions or physical defects predating original enlistment, these standards are applicable during the enlistees' initial period of active duty for training until their return to Reserve Component units.
      - (c) Applicants for reenlistment in the Regular Coast Guard and Coast Guard Reserve after a period of more than 6 months has elapsed since separation.
      - (d) Applicants for appointment as commissioned or warrant officers in the Coast Guard and as modified by section 3-E.
      - (e) Applicants for the United States Coast Guard Academy (USCGA) and all other special procurement programs, e.g., Officer Candidate School, and as modified by section 3-E.
      - (f) Cadets at the United States Coast Guard Academy, except for such conditions that have been diagnosed since entrance into the Academy. With respect to such conditions, upon recommendation of the senior medical officer, USCGA, the fitness standards of section 3-F are applicable for retention in the Academy. However, the standard in paragraph 3-D-39.p applies whether section 3-E or 3-F standards of this regulation are applicable.



- (g) Any individuals that may be inducted into the Coast Guard.
- (3) All numbers in parentheses refer to the ICD codes.
- b. Responsibilities. Commandant (G-WK) will:
  - (1) Revise Coast Guard policies to conform with the standards contained in DOD Directive 6130.4.
  - (2) Recommend to the Office of the Assistant Secretary of Defense (Health Affairs) [OASD(HA)] suggested changes in the standards after service coordination has been accomplished.
  - (3) Review all the standards on a quinquennial basis and recommend changes to the OASD(HA). This review will be initiated and coordinated by the DOD Medical Examination Review Board.
  - (4) Establish other standards for special programs.
  - (5) Issue Coast Guard-specific exceptions to these standards, having first submitted these, with justification, for review and approval by the OASD(HA).
- 3. Abdominal Organs and Gastrointestinal System. The causes for rejection for appointment, enlistment, and induction are authenticated history of:
  - a. Esophagus. Ulceration, varices, fistula, achalasia, or other dysmotility disorders; chronic, or recurrent esophagitis if confirmed by x-ray or endoscopic examination (530).
  - b. Stomach and duodenum.
    - (1) Gastritis, chronic hypertrophic, severe (535).
    - (2) Ulcer of stomach or duodenum confirmed by x-ray or endoscopy (533).
    - (3) Congenital abnormalities of the stomach or duodenum causing symptoms or requiring surgical treatment (751), except a history of surgical correction of hypertrophic pyloric stenosis of infancy.
  - c. Small and large intestine.
    - (1) Inflammatory bowel disease. Regional enteritis (555), ulcerative colitis (556), or ulcerative proctitis (556).
    - (2) Duodenal diverticula. That with symptoms or sequelae (hemorrhage, perforation, etc.) (562.02).
    - (3) Intestinal malabsorption syndromes. Including post surgical and idiopathic (579).
    - (4) Congenital (751): Condition to include Meckel's diverticulum or functional (564) abnormalities, persisting or symptomatic within the past two years.



- d. Gastrointestinal bleeding. History of such, unless the cause shall have been corrected and is not otherwise disqualifying (578).
  - e. Hepato-pancreatico-biliary tract.
    - (1) Viral hepatitis (070) or Unspecified hepatitis (570). Hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function, chronic hepatitis or hepatitis B carriers (070).
    - (2) Cholecystitis. Acute or chronic, with or without cholelithiasis (574); and other disorders of the gallbladder, including postcholecystectomy syndrome (575); and biliary system (576).
    - (3) Pancreatitis. Acute (577.0) and chronic (577.1).
  - f. Anorectal.
    - (1) Anal fissure if persistent, or anal fistula (565).
    - (2) Anal or rectal polyp (569.0), stricture (569.2), or incontinence (787.6).
    - (3) Hemorrhoids. Internal or external, when large, symptomatic, or history of bleeding (455).
  - g. Spleen.
    - (1) Splenomegaly. If persistent (789.2).
    - (2) Splenectomy (P41.5). Except when accomplished for trauma or conditions unrelated to the spleen, or for hereditary spherocytosis (282.0).
  - h. Abdominal wall.
    - (1) Hernia. Including inguinal (550) and other abdominal (553), except for small, or asymptomatic umbilical or hiatal.
    - (2) History of abdominal surgery during the preceding 60 days (P54).
  - i. Other. Gastrointestinal bypass (P43) or stomach stapling (p44) for control of obesity. Persons with artificial openings (V44).
4. Blood and Blood-Forming Tissue Diseases. The causes for rejection for appointment, enlistment, and induction are:
- a. Anemia. Any hereditary (282), acquired (283), aplastic (284), or unspecified (285) anemia that has not been permanently corrected with therapy.
  - b. Hemorrhagic disorders. Any congenital (286) or acquired (287) tendency to bleed due to a platelet or coagulation disorder.
  - c. Leukopenia. Chronic or recurrent (288), based on available norms for ethnic background.
  - d. Immunodeficiency (279).



5. Dental. The causes of rejection for appointment, enlistment, and induction are as follows:
  - a. Diseases of the Jaw or Associated Tissues That Are Not Easily Remediable, and Will Incapacitate the Individual or Otherwise Prevent the Satisfactory Performance of Duty. Those diseases include temporomandibular disorder (524.6) and/or myofascial pain dysfunction that is not easily corrected, or has the potential for significant future problems with pain and function.
  - b. Severe malocclusion (524). That malocclusion which interferes with normal mastication or requires early and protracted treatment; or relationship between mandible and maxilla that prevents satisfactory future prosthodontic replacement.
  - c. Insufficient Natural Healthy Teeth (521), or Lack of a Serviceable Prosthesis. Such condition preventing adequate mastication and incision of a normal diet. That includes complex (multiple fixture) dental implant systems that have associated complications that severely limit assignments and adversely affect performance of worldwide duty. Dental implant system must be successfully osseointegrated and completed
  - d. Orthodontic Appliances for Continued Treatment (V53.4). Attached or Removable. Retainer appliances are permissible, if all active orthodontic treatment has been satisfactorily completed
6. Ears. The causes for rejection for appointment, enlistment, and induction areas follows:
  - a. External ear. Atresia or severe microtia (744), acquired stenosis (380.5), severe chronic or acute external (380.2), or severe traumatic deformity (738.7).
  - b. Mastoids. Mastoiditis (383), residual of mastoid operation with fistula (383.81), or marked external deformity that prevents or interferes with the wearing of protective mask or helmet (383.3).
  - c. Meniere's Syndrome, or Other diseases of the Vestibular System (386).
  - d. Middle ear. Acute or chronic otitis media (382), cholesteatoma (385.3), or history of any inner (P20) or middle (P19) ear surgery, excluding myringotomy or successful tympanoplasty.
  - e. Tympanic membrane.
7. Hearing. The cause for rejection for appointment, enlistment, and induction is a hearing threshold level greater than that described in 3-D-7-a(3), below (389):
  - a. Audiometric Hearing Levels.
    - (1) Audiometers, calibrated to the International Standards Organization (ISO 1964) or the American National Standards Institute (ANSI 1969), shall be used to test the hearing of all applicants.



- (2) All audiometric tracings or audiometric readings recorded on reports of medical examinations or other medical records shall be clearly identified.
- (3) Acceptable audiometric hearing levels (both ears) are as follows:
  - (a) Pure tone at 500, 1000, and 2000 cycles per second of not more than 30 dB on the average with no individual level greater than 35 dB at those frequencies.
  - (b) Pure tone level not more than 45 dB at 3000 cycles per second and 55 dB at 4000 cycles per second.
- 8. Endocrine and Metabolic Disorders. The cause for rejection for appointment, enlistment, or induction are an authenticated history of the following:
  - a. Adrenal dysfunction (255). Of any degree.
  - b. Diabetes Mellitus (250). Of any type.
  - c. Glycosuria. Persistent, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4)
  - d. Acromegaly. Gigantism, or other disorder of pituitary function (253).
  - e. Gout (274).
  - f. Hyperinsulinism (251.1).
  - g. Hyperparathyroidism (252.0) and hypoparathyroidism (252.1).
  - h. Thyroid disorders.
    - (1) Goiter. Persistent or untreated (240).
    - (2) Hyperthyroidism. Condition uncontrolled by medication (244).
    - (3) Cretinism (243).
    - (4) Hypothyroidism (242).
    - (5) Thyroiditis (245).
  - i. Nutritional Deficiency Diseases. Such diseases include beriberi (265), pellagra (265.2), and scurvy (267).
  - j. Other Endocrine or Metabolic Disorders. Such disorders such as cystic fibrosis (277), porphyria (277.1), and amyloidosis (277.3) that prevent satisfactory performance of duty or require frequent or prolonged treatment.
- 9. Upper Extremities (see also section 3-D-11, below). The causes for rejection for appointment, enlistment, and induction areas follows:



- a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in EXHIBIT 3-F-1.
- (1) Shoulder (726.1).
    - (a) Forward elevation to 90 degrees.
    - (b) Abduction to 90 degrees.
  - (2) Elbow (726.3).
    - (a) Flexion to 100 degrees.
    - (b) Extension to 15 degrees.
  - (3) Wrist (726.4). A total range to 60 degrees (extension plus flexion). Radial and ulnar deviation combined arc 30 degrees.
  - (4) Hand.
    - (a) Pronation to 45 degrees.
    - (b) Supination to 45 degrees.
  - (5) Fingers and thumb (726.4). Inability to clench fist, pick up a pin, grasp an object or touch tips of at least 3 fingers with thumb.
- b. Hand and fingers.
- (1) Absence of the distal phalanx of either thumb(885).
  - (2) Absence of distal and middle phalanx of an index, middle, or ring finger of either hand irrespective of the absence of little finger (866).
  - (3) Absence of more than the distal phalanx of any two of the following fingers: index, middle finger, or ring finger of either hand (886).
  - (4) Absence of a hand or any portion thereof (887), except for fingers as noted above.
  - (5) Polydactyly (755).
  - (6) Scars and deformities of the fingers or hand (905.2) that are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of military duty.
  - (7) Intrinsic paralysis or weakness, including nerve palsy (354) sufficient to produce physical findings in the hand such as muscle atrophy or weakness.
- c. Wrist, Forearm, Elbow, Arm, and Shoulder. Recovery from disease or injury with residual weakness or symptoms such as to prevent satisfactory performance of duty (905.2), or grip strength of less than 75 percent of predicted normal when injured



hand is compared with the normal hand (nondominant is 80 percent of dominant grip).

10. Lower Extremities (see 3-D-11). The causes for rejection for appointment, enlistment, and induction are as follows:

- a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in EXHIBIT 3-F-1.

- (1) Hip. Due to disease(726.5) or injury (905.2).

- (a) Flexion to 90 degrees (minimum).
- (b) No demonstrable flexion contracture.
- (c) Extension to 10 degrees (beyond 0 degree).
- (d) Abduction to 45 degrees.
- (e) Rotation - 60 degrees (internal and external combined).

- (2) Knee. Due to disease (726.7) or injury (905.4).

- (a) Full extension compared with contralateral.
- (b) Flexion to 90 degrees.

- (3) Ankle. Due to disease (726.7) or injury (905.4).

- (a) Dorsiflexion to 10 degrees.
- (b) Plantar flexion to 30 degrees.
- (c) Eversion and inversion (total to 5 degrees).

- (4) Subtalar. Due to disease (726.7) or injury (905.4).

- (a) Eversion and inversion total to 5 degrees.

- b. Foot and ankle.

- (1) Absence of one or more small toes (895). If the function of the foot is poor, or running or jumping is prevented; absence of a foot (896) or any portion thereof except for toes as noted herein.
- (2) Absence of great toe(s) (895). Loss of dorsal and/or planter flexion if the function of the foot is impaired (905.4).
- (3) Deformities of the toes. Either acquired (735) or congenital (755.66), including polydactyly (755.02), that prevents the wearing of military footwear, or impairs walking, marching, running, or jumping. That includes hallux valgus (735).



- (4) Clubfoot and/or Pes Cavus (754.5). If stiffness or deformity prevents foot function or wearing military footwear.
- (5) Symptomatic Pes planus. Acquired (34) or congenital (754.6) or pronounced cases with absence of subtalar motion.
- (6) Ingrown toenails (703). If severe.
- (7) Planter Fasciitis (728.7). If persistent.
- (8) Neuroma (355.6). Confirmed condition and refractory to medical treatment, or will impair function of the foot.

c. Leg, knee, thigh, and hip.

- (1) Loose or foreign bodies in the knee joint (717.6). History of surgical correction of knee ligaments.
- (2) Physical findings of an unstable or internally deranged joint (717.9). History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury.
- (3) Surgical correction of any knee ligaments (P81), if symptomatic or unstable.
- (4) History of congenital dislocation of the hip (754.3). Osteochondritis of the hip (Legg-Perthes Disease) (732.1), or slipped femoral epiphysis of the hip (732.2).
- (5) Hip dislocation (835). Dislocation within 2 years before examination.
- (6) Osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) (732.4). If symptomatic.

d. General.

- (1) Deformities (905.4), disease, or chronic pain (719.4) of one or both lower extremities that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life; or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty.
- (2) Shortening of a lower extremity (736.81), resulting in a noticeable limp or scoliosis.

11. Miscellaneous Conditions of the Extremities. (see 3-D-9 and 3-D-10). The causes for rejection for appointment, enlistment, and induction areas follows:

a. Arthritis.

- (1) Active, subactive, or chronic arthritis (716).
- (2) Chronic osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints of more than a minimal degree, that has interfered with the following of a physically active vocation in civilian life or that prevents the satisfactory performance of military duty.



- b. Chronic retropatellar knee pain syndrome with or without confirmatory arthroscopic evaluation (717.7).
  - c. Dislocation, if unreduced; or recurrent dislocations of any major joint. Such as, shoulder (831), hip (835), elbow (832), knee (836); or stability of any major joint (shoulder(718.1), elbow (718.3, or hip(718.5)).
  - d. Fractures.
    - (1) Malunion or non-union of any fracture (733.8). Except ulnar styloid process.w
    - (2) Orthopedic hardware (733.99). hardware including plates, pins, rods, wires, or screws used for fixation and left in place; except that a pin, wire or screw not subject to easy trauma is not disqualifying.
  - e. Injury of a bone or joint. An injury of more than a minor nature, with or without fracture or dislocation, which occurred in the preceding 6 weeks (upper extremity (923), lower extremity (924), or rib and clavicle (922)).
  - f. Joint replacement (V43.6).
  - g. Muscular paralysis, contracture, or atrophy (728). If progressive or of sufficient degree to interfere with military service, and muscular dystrophies (359).
  - h. Osteochondritis dessicans (732.7).
  - i. Osteochondromatosis or multiple cartilaginous exostoses (727.82).
  - j. Osteomyelitis (730). Active or recurrent
  - k. Osteoporosis (733).
  - l. Scars (709.2). Extensive, deep, or adherent to the skin and soft tissues that interfere with muscular movements.
  - m. Implants. Silastic or other devices implanted or correct orthopedic abnormalities (V43).
12. Eyes. The cause for rejection for appointment, enlistment, or induction are as follows
- a. Lids.
    - (1) Blepharitis (373). Chroniccondition, of more than mild degree.
    - (2) Blepharospasm (333.81).
    - (3) Dacryocystitis. Acute or chronic (375.3).
    - (4) Deformity of the lids (374.4). Complete or extensive lid deformity, sufficient to interfere with vision or impair protection of the eye from exposure.



b. Conjunctiva.

- (1) Conjunctivitis. Chronic condition (372.1), including trachoma (076), and allergic conjunctivitis (372.13).
- (2) Ptergium (372.4). If condition encroaching on the cornea in excess of 3 millimeters, interfering with vision, progressive (372.42) or recurring after two operative procedures (372.45).
- (3) Xerophthalmia (372.53).

c. Cornea.

- (1) Dystrophy. Corneal dystrophy, of any type (371.5), including, keratoconus (371.6) of any degree.
- (2) Keratorefractive surgery. History of lamellar (P11.7) and/or penetrating keratoplasty (P11.6). Laser surgery or appliance utilized to reconfigure the cornea is also disqualifying.
  - (a) Waivers for Photorefractive Keratectomy (PRK) and Laser In-situ Keratomileusis (LASIK) will be considered if the following criteria are met:
    - 1 Pre-operative refractive error did not exceed +8.00 to -8.00 diopters (spherical equivalent) in either eye.
    - 2 At least 12 months since surgery or last enhancement.
    - 3 Refractive stability as demonstrated by less than 0.50 diopter change in either eye over two separate exams at least three months apart.
    - 4 All pre-operative, operative and post-operative records are submitted for review.
    - 5 No complications or side effects as a result of the surgery such as decreased night vision, glare sensitivity, halos around light or worsening of the pre-operative best vision due to scar formation.
    - 6 Accession standards outlined in section 3-D and 3-E are met.
  - (b) PRK and LASIK are disqualifying for aviation duty and landing signal officer duty.
  - (c) LASIK is disqualifying for diving duty.
- (3) Keratitis (370). Acute or chronic keratitis, which includes recurrent corneal ulcers, erosions (abrasions), or herpetic ulcers (054.42).
- (4) Vascularization (370.6) or opacification (371) of the cornea. Condition from any cause that is progressive or reduces vision below the standards prescribed in 3-D-13.



- d. Uveitis (364) or Iridocyclitis.
- e. Retina.
  - (1) Angiomas (759.6). Or other congenito-hereditary retinal dystrophy (362.7) that impairs visual function.
  - (2) Chorioretinitis (363). Unless single episode that has healed and does not interfere with vision.
  - (3) Congenital or degenerative changes of any part of the retina (362).
  - (4) Detachment of the retina (361). A history of surgery for same, or peripheral retinal injury or degeneration likely to cause retinal detachment.
  - (5) Chorioretinitis or inflammation of the retina (363). Condition including (histoplasmosis, toxoplasmosis or vascular conditions of the eye to include Coats' disease, Eales' disease, and retinitis proliferans), unless a single episode known cause that has healed and does not interfere with vision.
- f. Optic nerve.
  - (1) Optic neuritis (377.3). Neuroretinitis, or secondary optic atrophy or documented history of attacks of retrobulbar neuritis.
  - (2) Optic atrophy (377.1) or Cortical Blindness (377.7).
  - (3) Papilledema (377.0).
- g. Lens.
  - (1) Aphakia (379.3). Lens implant, or dislocation of a lens.
  - (2) Opacities of the lens (366). Those conditions that interfere with vision or that are considered to be progressive.
- h. Ocular mobility and motility.
  - (1) Diplopia (368.2). Documented, constant or intermittent.
  - (2) Nystagmus (379.5).
  - (3) Strabismus (378). Uncorrectable by lenses to less than 40 diopters or accompanied by diplopia.
  - (4) Strabismus. Corrective surgery (P15) in the preceding 6 months.
  - (5) See section 3-E for additional standards for officer programs.
- i. Miscellaneous defects and diseases.
  - (1) Abnormal visual fields due to diseases of the central nervous system (368.4), or trauma (368.9). Meridian specific visual field minimums areas follows:
    - (a) Temporal: 85 degrees.



- (b) Superior temporal: 55 degrees.
  - (c) Superior: 45 degrees.
  - (d) Superior nasal: 55 degrees.
  - (e) Nasal: 60 degrees.
  - (f) Inferior nasal: 50 degrees.
  - (g) Inferior: 65 degrees.
  - (h) Inferior temporal: 85 degrees.
  - (2) Absence of an eye. Congenital (743) or acquired (360.8).
  - (3) Asthenopia (368.13). Severe.
  - (4) Exophthalmos (376). Unilateral or bilateral, non-familial.
  - (5) Glaucoma (365). Primary, or secondary, or pre-glaucoma as evidenced by intraocular pressure above 21 mm/Hg, or the secondary changes in the optic disc or visual field loss associated with glaucoma.
  - (6) Loss of normal pupillary reflex reactions to light or accommodation (367.5) or light (379.4), including Adie's syndrome.
  - (7) Night blindness (368.6).
  - (8) Retained introcular foreign body (360).
  - (9) Tumors. Growths or tumors of the eyelid, other than small basal cell tumors that may be cured by treatment, and small nonprogressive asymptomatic benign lesions.
  - (10) Any organic disease of the eye (360) or adnexa (376) not specified above, that threatens vision or visual function.
13. Vision. The cause of medical rejection for appointment, enlistment, and induction are listed below. (See section 3-E for additional standards for officer programs.)
- a. Distant visual acuity. Distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367):
    - (1) 20/40 in one eye and 20/70 in the other eye.
    - (2) 20/30 in one eye and 20/100 in the other eye.
    - (3) 20/20 in one eye and not exceeding 20/400 in the other eye.
  - b. Near visual acuity. Near visual acuity of any degree that does not correct to 20/40 in the better eye (367).
  - c. Refractive error (Hyperopia 367.0, Myopia 367.1, Astigmatism 367.2). Any refractive error in spherical equivalent of worse than - 8.00 or + 8.00 diopters; or if



ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement; or if corrected by orthokeratology or keratorefractive surgery.

- d. Contact lenses. Complicated cases requiring contact lenses for adequate correction of vision such as corneal scars (371) and irregular astigmatism (367.2).
  - e. Color vision. (368.5). All applicants for initial entry into the Coast Guard, all officer candidates, all commissioning candidates, and all aviation candidates shall be tested for color vision. There is NO requirement for enlisted personnel to demonstrate normal color vision. A listing of current enlisted specialties that require normal color vision can be obtained from unit personnel offices or departments. Normal color vision IS required for all officer candidates and some commissioned warrant specialties (check with unit personnel offices for current listing).
14. Female Genitalia. The causes for rejection for appointment, enlistment, and induction areas follows:
- a. Abnormal uterine bleeding (626.2). Including such bleeding as menorrhagia, metrorrhagia or polymenorrhea.
  - b. Amenorrhea (626.0). Unexplained
  - c. Dysmenorrhea (625.3). Incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.
  - d. Endometriosis (617).
  - e. Hermaphroditism (752.7).
  - f. Menopausal Syndrome (627). If manifested by more than mild constitutional or mental symptoms or artificial menopause less than a 1-year duration.
  - g. Ovarian Cysts (620). Persistent or clinically significant.
  - h. Pelvic Inflammatory disease (614). Acute or chronic.
  - i. Pregnancy (V22).
  - j. Uterus. Congenital absence of (752.3) or enlargement due to any cause (621.2).
  - k. Vulvar or Vagina Ulceration (616.5). Including herpes genitalis (054.11) and condyloma acuminatum (078.11): acute or chronic, not amenable to treatment. Such treatment must be given and demonstrated effective prior to accession.
  - l. Abnormal Pap Smear (795). Graded LGSIL or higher severity; or any smear in which the descriptive terms carcinoma-in-situ, invasive cancer, condyloma accuminatum, human papilloma virus, or dysplasia are used.



- m. Major abnormalities and defects of the genitalia, such as a change of sex (P64.5). A history thereof, or dysfunctional residuals from surgical correction of these conditions.
15. Male Genitalia. The cause of medical rejection for appointment, enlistment, or induction are:
- a. Absence of both testicles. Congenital (752.8) or acquired (878.2), or unexplained absence of a testicle.
  - b. Epispadias or Hypospadias (752.6). when accompanied by evidence of infection of the urinary tract, or if clothing is soiled when voiding.
  - c. Undiagnosed enlargement or mass of testicle or epididymis (608.9).
  - d. Undescended testicle(s) (752.5).
  - e. Orchitis (604). Acute, or chronic epididymitis.
  - f. Penis. Amputation of (878), if the resulting stump is insufficient to permit micturition in a normal manner.
  - g. Penile infectious lesions. Including herpes genitalis (054.1) and condyloma acuminatum (078.11): acute or chronic, not amenable to treatment. Such treatment must be given and demonstrated effective prior to accession.
  - h. Prostatitis (601). Acute or chronic condition.
  - i. Hydrocele (603.9). Left varicocele (if painful), or any right varicocele (456.4)
  - j. Major abnormalities and defects of the genitalia, such as a change of sex (P64.5). A history thereof, or dysfunctional residuals from surgical correction of these conditions.
16. Urinary System The causes for rejection for appointment, enlistment, and induction are:
- a. Cystitis (595).
  - b. Urethritis (597).
  - c. Enuresis. (788.3) or incontinence of urine beyond age 12 (788.3).
  - d. Hematuria, Pyuria, or other findings indicative of urinary tract disease (599).
  - e. Urethral stricture (598) or fistula (599.1).
  - f. Kidney.
    - (1) Absence of one kidney. Congenital (753.0) or acquired (593.89).
    - (2) Infections. Acute or chronic infections (590).



- (3) Polycystic kidney (753.1). Confirmed history of such a condition.
  - (4) Horseshoe kidney (753.3).
  - (5) Hydronephrosis (591).
  - (6) Nephritis. Acute (580) or chronic (582).
  - (7) Proteinuria (791). Under normal activity (at least 48 hours after strenuous exercise) greater than 200 mg/24 hours, or a protein to creatinine ratio greater than 0.2 in a random urine sample, unless nephrologic consultation determines the condition to be benign orthostatic proteinuria.
  - (8) Renal Calculus (592). Within the previous 12 months, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.
17. Head. The causes for rejection for appointment, enlistment, and induction are:
- a. Injuries. Including severe contusions and other wounds of the scalp (920) and cerebral concussion (850), until a period of 3 months has elapsed. (See 3-D-27).
  - b. Deformities of the skull, face, or jaw (754.0). Such deformities of a degree that will prevent the individual from wearing a protective mask or military headgear.
  - c. Defects (756.0). Loss, or congenital absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving residual defect in excess of one square inch (6.45cm) or the size of a 25-cent piece.
18. Neck. The causes of rejection for appointment, enlistment, and induction are:
- a. Cervical ribs (756.2). If symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on x-rays is not considered to meet this criterion.)
  - b. Congenital cysts (744.4). Those cysts of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.
  - c. Contraction (723.8). Contraction of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment, or is so disfiguring as to impair military bearing.
19. Heart. The causes for rejection for appointment, enlistment, and induction are:
- a. All valvular heart diseases. Congenital (746) or acquired (394), including those improved by surgery, except mitral valve prolapse and bicuspid aortic valve. Those latter two conditions are not reasons for rejection unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.
  - b. Coronary heart disease (410).
  - c. Symptomatic arrhythmia or (electrocardiographic evidence of arrhythmia). A history of such condition.



- (1) Supraventricular tachycardia (427.0). Or any dysrhythmia originating from the atrium or sinoatrial node, such as atrial flutter, and atrial fibrillation unless there has been no recurrence during the preceding 2 years while off all medications. Premature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment
  - (2) Ventricular Arrhythmias (427.1). Those arrhythmias including ventricular fibrillation, tachycardia, and multifocal premature ventricular contractions. Occasional asymptomatic premature ventricular contractions are not disqualifying.
  - (3) Ventricular Conduction disorders. Such disorders with left bundle branch block (426.2), Mobitz type II second degree AV block (426.12). third degree AV block (426.0). Wolff-Parkinson-White syndrome (426.7) and Lown-Ganong-Levine Syndrome (426.81) associated with an arrhythmia are also disqualifying.
  - (4) Conduction Disturbances. Conduction disturbances such as first degree AV block (426.11), left anterior hemiblock (426.2), right bundle branch block (426.4) or Mobitz type I second degree AV block (426.13) are disqualifying when symptomatic or associated with underlying cardiovascular disease.
- d. Hypertrophy or dilatation of the heart (429.3).
  - e. Cardiomyopathy (425). Including myocarditis (422), or history of congestive heart failure (428) even though currently compensated.
  - f. Pericarditis (420).
  - g. Persistent tachycardia (785) (Resting pulse rate of 100 or greater).
  - h. Congenital anomalies of heart and great vessels (746). Except for corrected patent ductus arteriosus.
20. Vascular System. The causes for rejection for appointment, enlistment, and induction are:
- a. Abnormalities of the arteries and blood vessels (447). Abnormalities including aneurysms (442) even if repaired, atherosclerosis (440), and arteritis (446).
  - b. Hypertensive Vascular Disease (401). Such disease evidenced by the average of three consecutive averaged diastolic blood pressure measurements greater than 90 mmHg or three consecutive averaged systolic blood pressures greater than 140 mmHg at any age. High blood pressure requiring medication or a history of treatment including dietary restriction is also disqualifying.
  - c. Pulmonary (415) or systemic embolization (444).



- d. Peripheral Vascular Disease. Including diseases such as Raynaud's phenomenon (443).
  - e. Vein diseases. Vein disease including recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454).
21. Height. The causes for rejection for appointment, enlistment, and induction in relation to height standards are established by each of the military Services. Standards for the Coast Guard are:
- a. Men: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).
  - b. Women: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).
22. Weight. The causes for rejection for appointment, enlistment, and induction in relation to weight standards are contained in COMDTINST 1020.8(series).
23. Body Build. The cause for rejection for appointment, enlistment, and induction are:
- a. Congenital malformation of bones and joints. (See 3-D-9 through 3-D-11).
  - b. Deficient muscular development that would interfere with the completion of required training.
  - c. Evidence of congenital asthenia or body build that would interfere with the completion of required training.
24. Lungs, Chest Walls, Pleura, and Mediastinum. The causes for rejection for appointment, enlistment, and induction are:
- a. Abnormal elevation of the diaphragm (793.2). Such elevation may be either side.
  - b. Abscess of the lung (513).
  - c. Acute infectious process of the lung (518). Until cured.
  - d. Asthma (493). Including reactive airway disease, exercise-induced bronchospasm, or asthmatic bronchitis, reliably diagnosed at any age. Reliable diagnostic criteria shall consist of any of the following elements.
    - (1) Substantiated history of cough, wheeze, and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 6 months.
    - (2) If the diagnosis of asthma is in doubt, a test for reversible airflow obstruction (greater than a 15 percent increase in FEV I following administration of an inhaled bronchodilator), or airway hyperreactivity (exaggerated decrease in airflow induced by a standard bronchoprovocational challenge such as methacholine inhalation or a demonstration of exercise-induced bronchospasms) must be performed.



- e. Bronchitis (490). That which is chronic, symptoms over 3 months occurring at least twice a year.
  - f. Bronchiectasis (494).
  - g. Bronchopleural fistula (510).
  - h. Bullous or generalized pulmonary emphysema (492).
  - i. Chronic Mycotic disease (117) of the lung. Such diseases including coccidioidomycosis.
  - j. Chest Wall Malformation (754) or fracture (807). Those conditions that interfere with vigorous physical exertion.
  - k. Empyema (510). That condition includes residual pleural effusion (511.9), or unhealed sinuses of chest wall (510).
  - l. Extensive pulmonary fibrosis (515).
  - m. Foreign body in lung, trachea or bronchus (934).
  - n. Lobectomy. With residual pulmonary disease or removal of more than one lobe (P32.4).
  - o. Pleurisy with effusion (511.9). That condition occurring within the previous 2 years if known origin, or unknown origin.
  - p. Pneumothorax (512). That condition occurring during the year preceding examination if due to simple trauma or surgery, during the 3 years preceding examination from spontaneous origin. Recurrent spontaneous pneumothorax after surgical correction or pleural sclerosis.
  - q. Sarcoidosis. (See 3-D-35-j.)
  - r. Silicone breast implants. Those encapsulated (85.53P), if less than 9 months since surgery or with symptomatic complications.
  - s. Tuberculous lesions. (see subsection 3-D-35-l.)
25. Mouth. The cause for rejection for appointment, enlistment, and induction are:
- a. Cleft lip or palate defects (749). Unless satisfactorily repaired by surgery.
  - b. Leukoplakia (528.6).
26. Nose and Sinuses. The causes for rejection of appointment, enlistment, and induction are:
- a. Allergic manifestations.



- (1) Atrophic rhinitis. (472).
  - (2) Allergic rhinitis, vasomotor rhinitis (477). If moderate or severe and not controlled by oral medications, desensitization, or topical corticosteroid medication.
- b. Vocal cord paralysis (478.3). Or, symptomatic disease of the larynx (478.7).
  - c. Anosmia or parosmia (352).
  - d. Epistaxis (784.7). Recurrent condition.
  - e. Nasal polyps (471). Unless surgery was performed at least 1 year before examination.
  - f. Perforation of nasal septum (478.1). If symptomatic or progressive.
  - g. Sinusitis (461). Acute.
  - h. Sinusitis chronic (473). Such condition exists when evidenced by chronic purulent nasal discharge, hyperplastic changes of the nasal tissue, symptoms requiring frequent medical attention, or x-ray findings.
  - i. Larynx ulceration, polyps, or granulation tissue, or chronic laryngitis (476).
  - j. Tracheostomy (V44), or tracheal fistula (530.84).
  - k. Deformities or conditions (750.9). Those of the mouth, tongue, palate, throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech, or breathing.
  - l. Pharyngitis (462) and nasopharyngitis (472.2). Chronic conditions.
27. Neurological Disorders. The causes for rejection for appointment, enlistment, and induction are:
- a. Cerebrovascular conditions. Any history of subarachnoid (430) or intracerebral (431) hemorrhage, vascular insufficiency, aneurysm or arteriovenous malformation (437).
  - b. Congenital malformations (742). If associated with neurological manifestations, or if known to be progressive; meningocele (741), even if uncomplicated.
  - c. Degenerative and hereditodegenerative disorders. Those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), and peripheral nerves or muscles (337).
  - d. Recurrent headaches (784). Headaches of all types of sufficient severity or frequency as to interfere with normal function within the previous 3 years.



e. Head injury.

- (1) Applicants with a history of head injury with:
  - (a) Late post-traumatic epilepsy (occurring more than 1 week after injury).
  - (b) Permanent motor or sensory deficits.
  - (c) Impairment of intellectual function.
  - (d) Alteration of personality.
  - (e) Central nervous system shunts.
- (2) Applicants with a history of severe closed head injury are unfit for a period of at least 5 years after the injury. After 5 years they may be considered fit if complete neurological and neuropsychological evaluation shows no residual dysfunction or complications. Applicants with a history of severe penetrating head injury are unfit for a period of at least 10 years after the injury. After 10 years they may be considered fit if complete neurological and neuropsychological evaluation shows no residual dysfunction or complications. Severe head injuries are defined by one or more of the following.
  - (a) Unconsciousness or amnesia. Conditions alone or in combination of 24-hours duration or longer.
  - (b) Depressed skull fracture.
  - (c) Laceration or contusion of the dura mater or the brain.
  - (d) Epidural, subdural, subarachnoid or intracerebral hematoma.
  - (e) Associated abscess or meningitis.
  - (f) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.
  - (g) Focal neurologic signs.
  - (h) Radiographic evidence of retained metallic or bony fragments.
  - (i) Leptomeningeal cysts or arteriovenous fistula.
  - (j) Early post-traumatic seizure(s) that occur only within 1 week of injury but more than 30 minutes after injury.
- (3) Applicants with a history of moderate head injury. Those applicants are unfit for a period of at least 2 years after the injury. After 2 years they may be considered fit if complete neurological evaluation shows no residual dysfunction or complications. Moderate head injuries are defined as



unconsciousness or amnesia, alone or in combination, of 1 to 24 hours duration, or linear skull fracture.

- (4) Applicants with a history of mild head injury. Those applicants with mild head injuries, as defined by a period of unconsciousness or amnesia, alone or in combination, of 1 hour or less, are unfit for at least 1 month after the injury. After 1 month they be acceptable if complete neurological evaluation shows no residual dysfunction or complications.
- (5) Persistent post-traumatic seizure. Such conditions, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome, are disqualifying until full recovery has been confirmed by complete neurological and neuropsychological evaluation.

f. Infectious diseases.

- (1) Meningitis (322), encephalitis (323), or poliomyelitis (045). Such diseases occurring within 1 year before examination, or if there are residual neurological defects.
- (2) Neurosyphilis (094). That disease of any form (general paresis, tabes dorsalis, meningovascular syphilis).

g. Narcolepsy (347), sleep apnea syndrome (780.57).

h. Paralysis, weakness, lack of coordination, chronic pain, or sensory disturbances (344).

i. Epilepsy (345). That epilepsy occurring beyond the age of 5 years, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal electroencephalogram (EEG). All such applicants shall have a current neurology consultation with current EEG results. EEG may be requested by reviewing authority

j. Chronic disorders. Disorders such as myasthenia gravis (358), and multiple sclerosis (340).

k. Central nervous system shunts of all kinds (V45.2).

28. Disorders with Psychotic Features. The causes for rejection for appointment, enlistment, and induction are a history of a disorders with psychotic features (295).

29. Neurotic, Anxiety, Mood, Somatoform, Dissociative, or Factitious Disorders (300). The causes for rejection for appointment, enlistment, and induction are:

a. History of such disorders resulting in any or all of the below:

- (1) Admission to a hospital or residential facility.



- (2) Care by a physician or other mental health professional for more than 6 months.
  - (3) Symptoms or behavior of a repeated nature that impaired social, school, or work efficiency.
- 30. Personality, Conduct, and Behavior Disorders. The cause for rejection for appointment, enlistment, and induction are a history of such disorder resulting in any or all of the below:
  - a. Personality (301), Conduct (312), or Behavior (313) disorders. Disorders as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior that while not sufficient cause for administrative rejection, are tangible evidence of impaired capacity to adapt to military service.
  - b. Personality (301), Conduct (312), or Behavior (313) disorders. Where it is evident by history, interview, or psychological testing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency will seriously interfere with adjustment in the Coast Guard as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow workers, and other social groups.
  - c. Other behavior disorders including, but not limited to, conditions such as the following:
    - (1) Authenticated evidence of functional enuresis (307.6) or encopresis (307.7).
    - (2) Sleepwalking (307.6).
    - (3) Eating disorders that are habitual or persistent (307.1 or 307.5) occurring beyond age 12.
    - (4) Stammering (307.0) of such a degree that the individual is often unable to express himself or herself clearly, or to repeat commands.
  - d. Specific academic skills defects. Chronic history of academic skills (314) or perceptual defects (315), secondary to organic or functional mental disorders that interfere with work or school after age 12. Current use of medication to improve or maintain academic skills.
  - e. Suicide. History of attempted suicide or other suicidal behavior (300.9).
- 31. Psychosexual Conditions. The causes for rejection for appointment, enlistment, or induction are transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias (320).
- 32. Substance Misuse. The causes for rejection for appointment, enlistment, or induction are:
  - a. Alcohol dependence (303).
  - b. Drug dependence (304).



- c. Non-dependent use of drugs characterized by the following:
    - (1) The evidence of use of any controlled, hallucinogenic, or other intoxicating substance at the time of examination (305), when the use cannot be accounted for as a result of a prescription by a physician.
    - (2) Documented misuse or abuse of any controlled substance (including cannabinoids or anabolic steroids) requiring professional care (305).
    - (3) The repeated self-procurement and self-administration of any drug or chemical substance, including cannabinoids or anabolic steroids, with such frequency that it appears that the applicant has accepted the use of or reliance on those substances as part of his or her pattern of behavior (305).
    - (4) The use of LSD (305.3) in a 2-year period before examination.
  - d. Alcohol abuse (305). Use of alcoholic beverages, which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility, or a disrupted personal relationship.
33. Skin and Cellular Tissues. The causes for rejection for appointment, enlistment, and induction are:
- a. Acne (706). Severe acne, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment and not amenable to treatment. Patients under treatment with isotretinoin (Accutane) are medically unacceptable until 8 weeks after completion of a course of therapy.
  - b. Atopic dermatitis (691) or eczema (692). Occurring with active or residual lesions in characteristic areas (face and neck, antecubital and/or popliteal fossae, occasionally wrists and hands), or documented history thereof after the age of 8.
  - c. Contact dermatitis (692.4). Dermatitis especially involving rubber or other materials used in any type of required protective equipment.
  - d. Cysts.
    - (1) Cysts (706.2), other than pilonidal. Cysts of such a size or location as to interfere with the normal wearing of military equipment.
    - (2) Cysts, pilonidal (685). Pilonidal cysts evidenced by the presence of a tumor mass or discharging sinus. History of pilonidal cystectomy within 6 months before examination.
  - e. Dermatitis factitia (698.4).
  - f. Bullous dermatoses (694). Conditions such as dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.



- g. Chronic lymphedema (457).
- h. Fungus infections (117). Systemic or superficial types, if extensive and not amenable to treatment.
- i. Furunculosis (680). Extensive, recurrent, or chronic.
- j. Hyperhidrosis of hands or feet (780.8). Chronic or severe.
- k. Ichthyosis. Or other congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function or are exposed to constant irritation.
- l. Keloid formation (701-4). If the tendency is marked or interferes with the wearing of military equipment.
- m. Leprosy (030.9).
- n. Lichen planus (697.0).
- o. Neurofibromatosis (Von Recklinghausen's disease) (237.7).
- p. Photosensitivity (692.72). Any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.
- q. Psoriasis (696.1). Unless mild by degree, not involving nail-pitting, and not interfering with the wearing of military equipment or clothing.
- r. Radiodermatitis (692.82).
- s. Scars (709.2). Scars so extensive, deep, or adherent that they may interfere with the wearing of military clothing or equipment, exhibit a tendency to ulcerate, or interfere with function. Includes scars at skin graft donor or recipient sites if in an area susceptible to trauma.
- t. Scleroderma (710.1).
- u. Tattoos (709.9). Entrance may be denied to any applicant who has a tattoo or other applied body marking contrary to the core values of the Coast Guard in accordance with "Tattoo and Body Markings Policy for CG Accessions, COMDTINST 1000.1."
- v. Urticaria (708.8). Chronic.
- w. Warts. Plantar warts (078.19) that are symptomatic.
- x. Xanthoma (272.2). If disabling or accompanied by hyperlipemia.



- y. Any other chronic skin disorder of a degree or nature such as Dysplastic nevi syndrom (448.1), which requires frequent outpatient treatment or hospitalization, or interferes with the satisfactory performance of duty.
34. Spine and Sacroiliac Joints. The causes for rejection for appointment, enlistment, and induction are:
- a. Arthritis (720). (see 3-D-11.a)
  - b. Complaint of a disease or injury of the spine or sacroiliac joints, with or without objective signs, that has prevented the individual from successfully following a physically active vocation in civilian life (724), or that is associated with pain referred to the lower extremities, muscular spasms, postural deformities, or limitation of motion.
  - c. Deviation or curvature of spine (737) from normal alignment, structure, or function if:
    - (1) It prevents the individual from following a physically active vocation in civilian life.
    - (2) It interferes with the wearing of a uniform or military equipment.
    - (3) It is symptomatic and associated with positive physical finding(s) and demonstrable by x-ray.
    - (4) There is lumbar scoliosis greater than 20 degrees, thoracic scoliosis over 20 degrees, and kyphosis or lordosis greater than 55 degrees when measured by the Cobb method.
  - d. Fusion. Congenital fusion (756.15), involving more than two vertebrae. Any surgical fusion (81.0P).
  - e. Healed fractures or dislocations of the vertebrae (805). A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.
  - f. Juvenile epiphysitis (732.6). That with any degree of residual change indicated by x-ray or kyphosis.
  - g. Ruptured nucleus pulposus (722). Herniation of intervertebral disk or surgery for this condition.
  - h. Spina bifida (741). When symptomatic, or there is more than one vertebra involved, dimpling of the overlying skin, or a history of surgical repair.
  - i. Spondylolysis (756.1) and Spondylolisthesis (738.4).



- j. Weak or painful back (724). Back condition requiring external support; that is, corset or brace. Recurrent sprains or strains requiring limitation of physical activity or frequent treatment.
35. Systemic Diseases. The causes for rejection for appointment, enlistment, and induction are:
- a. Amyloidosis (277.3).
  - b. Ankylosing spondylitis (720).
  - c. Eosinophilic granuloma (277.8). Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, shall not be a cause for rejection once healing has occurred. All other forms of the histiocytosis X spectrum should be rejected.
  - d. Lupus erythematosus (710) and mixed connective tissue disease (710.9).
  - e. Polymyositis dermatomyositis complex (710).
  - f. Progressive systemic sclerosis (710). Condition including CRST variant. A single plaque of localized scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.
  - g. Reiter's disease (099.3).
  - h. Rheumatoid arthritis (714).
  - i. Rhabdomyolysis (728.9).
  - j. Sarcoidosis (135). Unless there is substantiated evidence of a complete spontaneous remission of at least 2 years duration.
  - k. Sjogren's syndrome (710.2).
  - l. Tuberculosis (010).
    - (1) Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.
    - (2) One or more reactivations.
    - (3) Residual physical or mental defects from past tuberculosis that will prevent the satisfactory performance of duty.
    - (4) Individuals with a past history of active tuberculosis more than 2 years prior to enlistment or induction, are qualified if they have received a complete course of standard chemotherapy for tuberculosis. In addition, individuals with a tuberculin reaction 10 mm or greater and without evidence of residual disease are qualified once they have been treated with chemoprophylaxis



(5) Vasculitis (466). Such as Bechet's, Wegener's granulomatosis polyarteritis nodosa.

36. General and Miscellaneous Conditions and Defects. The causes for rejection for appointment, enlistment, and induction are:

- a. Allergic manifestations (995.0). A reliable history of anaphylaxis to stinging insects. Reliable history of a moderate to severe reaction to common foods, spices or food additives.
- b. Any acute pathological condition. Those including acute communicable diseases, until recovery has occurred without sequelae.
- c. Chronic metallic poisoning. Poisoning with lead, arsenic, or silver (985), or beryllium or manganese (985).
- d. Cold injury (991). Residuals of injury; such as frostbite, chilblain, immersion foot, trench foot, deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.
- e. Cold urticaria (708.2) and angiodema, hereditary angiodema (277.6).
- f. Filariasis (125), Trypanosomiasis (086), Schistosomiasis (120).
- g. Heat pyrexia (992) heatstroke (992), or sunstroke (992). Documented evidence of a predisposition (including disorders of sweat mechanism and a previous serious episode), recurrent episodes requiring medical attention, or residual injury (especially cardiac, cerebral, hepatic, and renal). Malignant Hyperthermia (995.89).
- h. Industrial solvent and other chemical intoxication (982).
- i. Motion sickness (994.6). An authenticated history of frequent, incapacitating motion sickness after the 12<sup>th</sup> birthday.
- j. Mycotic (114) infection of internal organs.
- k. Organ transplant recipient (V42).
- l. Presence of HIV-1 or antibody (042). That presence confirmed by repeatedly reactive Enzyme-Linked Immunoassay (ELISA) serological test and positive immunoelectrophoresis (Western Blot) test, or other DoD approved screening and confirmatory test.
- m. Reactive tests for syphilis (093). Test such as the RPR or VDRL followed by a reactive, confirmatory fluorescent treponemal antibody absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical findings, the presence of reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified and is not otherwise disqualifying.



- n. Residual of tropical fevers. Fevers such as malaria (084) and various parastic or protozoan infestations that prevent the satisfactory performance of military duty.
  - o. Rheumatic fever (390). That condition during the previous 2 years, or any history or recurrent attacks; Sydenham's chorea at any age.
  - p. Sleep apnea (780.57).
37. Tumors and Malignant Diseases. The causes for rejection for appointment, enlistment, and induction are:
- a. Benign tumors (M8000). Those that interfere with function, prevent wearing of the uniform or prtective equipment, shall require frequent specialized attention, or have a high malignant potential.
  - b. Malignant tumors (V10). Exception for basal cell carcinoma, removed with no residual. In addition, the following cases should be qualified, if on careful review they meet the following criteria:
    - (1) Individuals who have a history of childhood cancer and who have not received any surgical or medical cancer therapy for 5 years and are free of cancer
    - (2) Individuals with a history of Wilm's tumor and germ cell tumors of the testis treated surgically and/or with chemotherapy in childhood after a 2-year disease-free interval off all treatment.
    - (3) Individuals with a history of Hodgkins' disease treated with radiation therapy and/or chemotherapy and disease free off treatment for 5 years.
    - (4) Individuals with a history of large cell lymphoma after 2-years disease-free interval off all therapy.
  - c. Miscellaneous. Any condition that, in the opinion of the examining medical officer, will significantly interfere with the successful performance of military duty or training (796).



FIGURE 3-D-1

| EVALUATION FOR RISK OF HEAD INJURY SEQUELAE |   |   |
|---|---|---|
| DEGREE OF HEAD INJURY                       | MINIMUM   | EVALUATION REQUIREMENTS   |
| MILD  | ONE MONTH   | COMPLETE NEUROLOGICAL EXAMINATION BY A PHYSICIAN  |
| MODERATE                                    | TWO YEARS   | COMPLETE NEUROLOGICAL EVALUATION BY A NEUROLOGIST OR INTERNIST<br>CT SCAN                                   |
| SEVERE                                      | FIVE YEARS FOR CLOSED HEAD TRAUMA<br><br>TEN YERS FOR PENETRATING HEAD TRAUMA | COMPLETE NEUROLOGICAL EVALUATION BY NEUROLOGIST OR NEUROSURGEON<br>CT SCAN<br>NEUROPSYCHOLOGICAL EVALUATION |



FIGURE 3-D-2  
CLASSIFICATION AND COMPARATIVE NOMENCLATURE OF CERVICAL SMEARS

| Original Classification  | CIN System  | Bethesda System  |
|--|---|--|
| Class I:<br>No abnormal cells  | Normal smear;   |  |
| Class II: Atypical cells present<br>below the level of<br>cervical neoplasia                   |   | Atypical squamous<br>cells of undetermined<br>significance |
| Class III: Smear contains abnormal<br>cells consistent with<br>dysplasia                       | Mild dysplasia = CIN1<br>Moderate dysplasia =<br>CIN2 | Low-grade SIL<br>(Changes asso-<br>ciated with HPV & CIN1) |
| Class IV Smear contains abnormal<br>cells consistent with<br>carcinoma-in-situ                 | Severe dysplasia and<br>carcinoma-in-situ =<br>CIN3   | High-grade SIL<br>(CIN2, CIN3, and<br>carcinoma-in-situ)   |
| Class V: Smear contains abnormal<br>cells consistent with carcinoma<br>squamous cell carcinoma |   | Squamous cell carcinoma                                    |

Abbreviations: CIN = cervical intraepithelial neoplasia

Section A - SIL = squamous intraepithelial lesion



Section E      Physical Standards for Programs Leading to Commission

1. Appointment as Cadet, United States Coast Guard Academy.

a. Physical Examinations.

- (1) Applicants are encouraged to review the physical standards as published in the Academy Bulletin with their private physician prior to submitting their application for cadet candidate. This review serves to rule out, at this stage of the potential cadet's processing, applicants who obviously will not meet the required physical standards for appointment. In some cases, the physician may recommend a complete physical examination. Inaccuracy in ascertaining defects and determining the candidate's physical status at the time of this review results in unnecessary work for the Coast Guard and disappointment to the candidate when defects are subsequently found during the formal physical examination.
- (2) Candidates and their parents and sponsors are urged to refrain from requesting waivers for medical defects. The Coast Guard bases its decision to disqualify an individual on medical facts revealed in a thorough physical examination. Candidates unable to satisfy the minimum requirements are not suited for commission in the Regular Coast Guard, and consequently are not eligible for training at the Academy. A request for waiver for a medical defect invariably results in disappointment to all concerned.
- (3) Two physical examinations are required:
  - (a) formal physical examination before appointment is tendered; and
  - (b) pretraining examination at the time of reporting to the Academy.
- (4) Formal physical examinations prior to accepting of candidates must be performed by a U. S. Public Health Service, Navy, Army, Air Force, or Veteran's Administration medical officer authorized to perform each exam by Department of Defense Medical Examination Review Board (DODMERB). All candidates are instructed where to report for such examinations.

b. Physical Standards. All candidates for the Coast Guard Academy must meet the physical standards for enrollment as an officer candidate. DODMERB is reviewing authority.

c. Retention. The standards for retention of a cadet at the Academy are the same as those for enrollment as an officer candidate, except that the Superintendent of the Academy is authorized to establish physical fitness and weight control programs designed to have cadets maintain weight closer to the ideal than the standards stipulated elsewhere for Service personnel. These stricter goals during cadet years are intended to take advantage of the Academy's unique environment of rigorous physical activity combined with opportunities for diet control and weight monitoring.



These programs will instill lifelong behavior patterns to support the Service weight control standards.

2. Commissioning of Cadets. The preappointment physical examination of cadets in the graduating class should be held at least 6 months prior to acceptance of the commission. This physical examination should be conducted to determine physical fitness for commission in the Regular Service (section 3-D and 3-E) with recommendations made accordingly. Cadets should not be summarily disqualified for commissioning merely because they do not meet the standards for appointment as cadets provided that they may reasonably be expected to be physically capable of completing a full and effective Coast Guard career. In general, relatively minor defects that would be disqualifying for original commission direct from civilian life are not disqualifying for commission of a cadet in whom the Government has a considerable investment.
3. Enrollment as an Officer Candidate.
  - a. Physical Examination. The physical examination for an officer candidate must be conducted by a medical officer and a dentist. Particular care must be exercised during the examination in order that candidates may not be rejected later as a result of reexamination at Officer Candidate School. A complete physical examination is given officer candidates upon arrival at OCS to determine medical fitness and freedom from disease. Physician Assistant Officer Candidates will only receive an initial OCS candidate physical.
  - b. Physical Standards for Enrollment. The standards contained in section 3-D (section 3-F for enlisted OCS candidates), as modified below, are applicable for enrollment as an officer candidate. Conditions not enumerated, that in the medical examiner's opinion will not permit a full productive career, shall be recorded in detail with appropriate recommendations.
    - (1) Distant Visual Acuity. Uncorrected visual acuity shall be not worse than 20/400 in either eye provided that vision is correctable to 20/20 and that refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder), astigmatism does not exceed 3.00 diopters, and anisometropia does not exceed 3.50 diopters. Eyes must be free from any disfiguring or incapacitating abnormality and from acute or chronic disease. All personnel requiring corrective lenses shall wear them for the performance of duty.
    - (2) Near visual acuity of any degree that does not correct to 20/40 in the better eye.
    - (3) Normal color perception.
    - (4) Teeth.
      - (a) All candidates shall be given a Type II dental examination by a dental officer, as part of the pre-training physical examination.
      - (b) Caries. No more than four teeth may exhibit multi-surface caries.



- (c) Endodontics. The need for endodontic intervention on seven or more canals is disqualifying.
- (d) Maxillary and Mandibular Bones. Malunited fractures of maxillary or mandibular bones and deformities of maxillary or mandibular bones interfering with mastication or speech are disqualifying. The presence of extensive necrosis or osseous lesions requiring surgical intervention are also disqualifying.
- (e) Oral Tissues. Extensive loss of oral tissues that would prevent the replacement of missing teeth with a satisfactory prosthetic appliance is disqualifying. Unresolved oral inflammatory diseases are disqualifying. Hypertrophic, hyperplastic, or leukoplakic conditions of the soft tissue of the oral cavity may be disqualifying and will be considered on a case-by-case basis.
- (f) Periodontal Disease. The presence of advanced periodontal disease is disqualifying.
- (g) Serviceable Teeth. A sufficient number of teeth, natural or artificial, in functional occlusion to assure satisfactory incision, mastication, and phonation are required. The minimum requirement is edentulous upper and lower jaws corrected by full dentures. A requirement for placement of a prosthesis to meet the above requirements is disqualifying.
- (h) Temporomandibular Joint. Current symptoms and/or history of chronic temporomandibular joint dysfunction is disqualifying (see also section 3-D-16.b).

4. Commissioning of Officer Candidates.

- a. The physical examination given upon arrival at OCS precludes the need for a commissioning physical examination providing there has been no intervening change in physical status and a visual acuity and color perception examination are given prior to actual commissioning.
- b. The physical standards for commissioning are the same as for enrollment as an officer candidate. Final determination as to physical fitness for commissioning is made by the Commandant.

5. Direct Commission in the Coast Guard Reserve.

- a. Nonaviator. The physical examination and standards for direct commission in the Reserve are the same for enrollment of officer candidates, except that Ready Reserve Direct Commission (RRDC) examinations must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).
- b. Aviator. Candidates for direct commission in the Reserve as aviators must obtain an aviation physical examination from a currently qualified uniformed services flight



surgeon or AMO within the last 12 months. The candidate must meet the standards for Class I, contained in section 3-G.

6. Direct Commission of Licensed Officers of U. S. Merchant Marine.

- a. Physical Examination. Two physical examinations are required: a preliminary physical at the time of the written examination; and a preappointment physical examination taken by successful candidates within six months of actual commission. The physical examination must be conducted by a medical officer of the uniformed services on active duty. Final determination of physical fitness will be made by the Commandant.
- b. Physical Standards. The physical standards for direct commission of Licensed Officers of the U. S. Merchant Marine are the same as for enrollment of officer candidates. All these standards must be met without waiver.

7. Appointment to Warrant Grade.

- a. Physical Examination. A complete physical examination is required within 12 months prior to appointment to Warrant Officer, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).
- b. Physical Requirements. The physical standards for appointment of Coast Guard members to Warrant Officer are the same as for retention of officers in the regular Coast Guard. See section 3-F for the standards. The physical standards for all other applicants are the same as for enrollment of officer candidates.



Section F Physical Standards Applicable to All Personnel (Regular and Reserve) For: Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty.

1. General Instructions.

- a. Scope. This section establishes specific physical standards applicable to all personnel (regular and reserve) for:
  - (1) enlistment/reenlistment of prior service USCG personnel within 6 months of discharge from active duty in the Regular Coast Guard;
  - (2) retention;
  - (3) overseas duty; and
  - (4) sea duty.
- b. Physical Examinations. Physical examinations should be conducted by at least one medical and one dental officer of the uniformed services or by contract physician/dentist.
- c. Fitness for Duty. Members are ordinarily considered fit for duty unless they have a physical impairment (or impairments) that interferes with the performance of the duties of their grade or rating. A determination of fitness or unfitness depends upon the individual's ability to reasonably perform those duties. Members considered temporarily or permanently unfit for duty shall be referred to an Initial Medical Board for appropriate disposition.

2. Use of List of Disqualifying Conditions and Defects. This section lists certain medical conditions and defects that are normally disqualifying. However, it is not an all-inclusive list. Its major objective is to achieve uniform disposition of cases arising under the law, but it is not a mandate that possession of one or more of the listed conditions or physical defects means automatic retirement or separation. The listed conditions or defects (and any other not listed) considered as disqualifying shall be referred to an Initial Medical Board, or waiver requested, as appropriate. See additional guidance in paragraphs 3-B-6 and 3-B-7 concerning separation physicals.

3. Head and Neck.

- a. Loss of substance of the skull. With or without prosthetic replacement when accompanied by moderate residual signs and symptoms.
- b. Torticollis (wry neck). Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

4. Esophagus, Nose, Pharynx, Larynx, and Trachea.



a. Esophagus.

- (1) Achalasia. Manifested by dysphagia (not controlled by dilation), frequent discomfort, inability to maintain normal vigor and nutrition, or requiring frequent treatment.
- (2) Esophagitis. Persistent and severe.
- (3) Diverticulum of the esophagus. Of such a degree as to cause frequent regurgitation, obstruction and weight loss, that does not respond to treatment.
- (4) Stricture of the esophagus. Of such a degree as to almost restrict diet to liquids, require frequent dilation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

- (1) Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.
- (2) Stenosis of the larynx. Causing respiratory embarrassment upon more than minimal exertion.
- (3) Obstruction edema of glottis. If chronic, not amenable to treatment and requiring tracheotomy.

c. Nose, Pharynx, Trachea.

- (1) Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting and concomitant severe headaches.
- (2) Sinusitis. Severe and chronic that is suppurative, complicated by polyps, and does not respond to treatment.
- (3) Trachea. Stenosis of trachea that compromises airflow to more than a mild degree.

5. Eyes.

a. Diseases and Conditions.

- (1) Active eye disease. Or any progressive organic disease regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual field so that:
  - (a) distant visual acuity does not meet the standards; or
  - (b) the diameter of the field of vision in the better eye is less than 20°.
- (2) Aphakia, bilateral. Regardless of lens implant(s).
- (3) Atrophy of optic nerve.
- (4) Glaucoma. If resistant to treatment, or affecting visual fields, or if side effects of required medications are functionally incapacitating.



- (5) Diseases and infections of the eye. When chronic, more than mildly symptomatic, progressive and resistant to treatment after a reasonable period.
- (6) Ocular manifestations of endocrine or metabolic disorders. Not disqualifying, per se; however, residuals or complications, or the underlying disease may be disqualifying.
- (7) Residuals or complications of injury. When progressive or when reduced visual acuity or fields do not meet the standards.
- (8) Retina, detachment of.
  - (a) Unilateral.
    - 1 When visual acuity does not meet the standards.
    - 2 When the visual field in the better eye is constricted to less than 20°.
    - 3 When uncorrectable diplopia exists.
    - 4 When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.
  - (b) Bilateral. Regardless of etiology or results of corrective surgery.

b. Vision

- (1) Aniseikonia. Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonic lenses.
- (2) Binocular diplopia. Which is severe, constant, and in zone less than 20° from the primary position.
- (3) Hemianopsia. Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not normally disqualifying.
- (4) Night blindness. Of such a degree that the individual requires assistance in any travel at night.
- (5) Visual Acuity.
  - (a) Visual acuity that cannot be corrected to at least 20/50 in the better eye.
  - (b) Complete blindness or enucleation of an eye.
  - (c) When vision is correctable only by the use of contact lenses or other corrective device (telescope lenses, etc.).



- (6) Visual Fields. When the visual field in the better eye is constricted to less than 20°.
- (7) Color Perception. Normal color perception is required for retention of commissioned officers (certain warrant officer specialties do not require normal color perception) and selected ratings [See the Personnel Manual, COMDTINST M1000.6 (series) and Chapter 5-C-11]. Retesting for color perception is not required if results of previous tests are documented in the health record, and there has been no history of a change in color vision.

c. Corneal Refractive Surgery.

- (1) The refractive surgery procedures radial keratotomy (RK), and intracorneal rings (ICR) are disqualifying and not waivable.
- (2) Photorefractive keratectomy (PRK) and laser in-situ keratomileusis (LASIK) are disqualifying for aviation duty, landing signal officer duty and not waivable.
- (3) LASIK is disqualifying for diving duty and not waivable.
- (4) Photorefractive keratectomy (PRK) is not disqualifying for non-aviation members, including diving personnel, and does not require a waiver if the following conditions are met:
  - (a) Must follow guidelines for elective health care contained in 2.A.6.
  - (b) There must be post surgical refractive stability defined as less than 0.50 diopter change over two separate exams at least three months apart.
  - (c) Must meet all vision standards in 3-F.5.b (divers must meet vision standards in 3-H.2.h). If the member is unable to meet these standards they will be considered for separation as outlined in the Physical Disability Evaluation System, COMDTINST M1850.2(series).
- (5) LASIK is not disqualifying for non-aviation personnel, excluding diving personnel and does not require a waiver as long as the following conditions are met:
  - (a) Must follow guidelines for elective health care contained in 2.A.6.
  - (b) There must be post surgical refractive stability defined as less than 0.50 diopter change over two separate exams at least three months apart.
  - (c) Must meet all vision standards in 3-F.5.b. If the member is unable to meet these standards they will be considered for separation as outlined in the Physical Disability Evaluation System, COMDTINST M1850.2(series).



6. Ears and Hearing.

a. Ears.

- (1) Infections of the external auditory canal. Chronic and severe, resulting in thickening and excoriation of the canal, or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.
- (2) Malfunction of the acoustic nerve. Evaluate hearing impairment.
- (3) Mastoiditis, chronic. Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.
- (4) Mastoidectomy. Followed by chronic infection with constant or recurrent drainage requiring frequent or prolonged medical care.
- (5) Meniere's Syndrome. Recurring attacks of sufficient frequency and severity as to interfere with satisfactory performance of military duty, or require frequent or prolonged medical care.
- (6) Otitis Media. Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent or prolonged medical care.

b. Hearing. Retention will be determined on the basis of ability to perform duties of grade or rating.

7. Lungs and Chest Wall.

a. Tuberculous Lesions. See chapter 7 of this Manual.

(1) Pulmonary tuberculosis.

- (a) When an active duty member's disease is found to be not incident to military service, or when treatment and return to useful duty will probably require more than 15 months, including an appropriate period of convalescence, or if expiration of service will occur before completion of period of hospitalization. (Career members who express a desire to reenlist after treatment may extend their enlistment to cover period of hospitalization.)
- (b) When a Reservist not on active duty has TB that will probably require treatment for more than 12 to 15 months including an appropriate period of convalescence before being able to perform full-time military duty. Individuals who are retained in the Reserve while undergoing treatment may not be called or ordered to active duty (including mobilization), active duty for training, or inactive duty training during the period of treatment and convalescence.

b. Nontuberculous Conditions. Pulmonary diseases, other than acute infections, must be evaluated in terms of respiratory function, manifested clinically by measurements



that must be interpreted as exertional or altitudinal tolerance. Symptoms of cough, pain, and recurrent infections may limit a member's activity. Many of the conditions listed below may coexist and in combination may produce unfitness.

- (1) Atelectasis, or massive collapse of the lung. Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day, or with moderate emphysema, or with residuals or complications that require repeated hospitalization.
- (2) Bronchial Asthma. Associated with emphysema of sufficient severity to interfere with the satisfactory performance of duty, or with frequent attacks not controlled by inhaled or oral medications, or requiring oral corticosteroids more than twice a year.
- (3) Bronchiectasis or bronchiolectasis. Cylindrical or saccular type that is moderately symptomatic, with productive cough at frequent intervals throughout the day, or with moderate other associated lung disease to include recurrent pneumonia, or with residuals or complications that require repeated hospitalization.
- (4) Bronchitis. Chronic, severe persistent cough, with considerable expectoration, or with moderate emphysema, or with dyspnea at rest or on slight exertion, or with residuals or complications that require repeated hospitalization.
- (5) Cystic disease of the lung, congenital. Involving more than one lobe of a lung.
- (6) Diaphragm, congenital defect. Symptomatic.
- (7) Hemopneumothorax, hemothorax, or pyopneumothorax. More than moderate pleuritic residuals with persistent underweight, or marked restriction of respiratory excursion and chest deformity, or marked weakness and fatigability on slight exertion.
- (8) Histoplasmosis. Chronic and not responding to treatment.
- (9) Pleurisy, chronic or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.
- (10) Pneumothorax, spontaneous. Repeated episodes of pneumothorax not correctable by surgery.
- (11) Pneumoconiosis. Severe with dyspnea on mild exertion.
- (12) Pulmonary calcification. Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.
- (13) Pulmonary emphysema. Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.
- (14) Pulmonary fibrosis. Linear fibrosis or fibrocalcific residuals that cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.



- (15) Pulmonary sarcoidosis. If not responding to therapy and complicated by demonstrable moderate reduction in pulmonary function.
  - (16) Stenosis, bronchus. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring frequent hospitalization.
  - c. Surgery of the Lungs and Chest. Lobectomy. If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.
8. Heart and Vascular System.
- a. Heart.
    - (1) Arrhythmias. Associated with organic heart disease, or if not adequately controlled by medication or if they interfere with satisfactory performance of duty.
    - (2) Arteriosclerotic disease. Associated with congestive heart failure, repeated anginal attacks, or objective evidence of myocardial infarction.
    - (3) Endocarditis. Bacterial endocarditis resulting in myocardial insufficiency or associated with valvular heart disease.
    - (4) Heart block. Associated with other symptoms of organic heart disease or syncope (Stokes-Adams Syndrome).
    - (5) Myocarditis and degeneration of the myocardium. Myocardial insufficiency resulting in slight limitation of physical activity.
    - (6) Pericarditis.
      - (a) Chronic constrictive pericarditis unless successful remedial surgery has been performed.
      - (b) Chronic serous pericarditis.
    - (7) Rheumatic valvulitis and valvular heart disease. Cardiac insufficiency at functional capacity and therapeutic level of class IIC or worse, American Heart Association. A diagnosis made during the initial period of service or enlistment that is determined to be a residual of a condition that existed prior to entry in the service is disqualifying regardless of severity.
  - b. Vascular System.
    - (1) Arteriosclerosis obliterans. When any of the following pertain:
      - (a) intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest; or
      - (b) objective evidence of arterial disease with symptoms of claudication, ischemic chest pain at rest, or with gangrenous or permanent ulcerative skin changes in the distal extremity; or



- (c) involvement of more than one organ system or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.
- (2) Congenital anomalies. Coarctation of aorta and other congenital anomalies of the cardiovascular system unless satisfactorily treated by surgical correction.
- (3) Aneurysms. Aneurysm of any vessel not correctable by surgery and producing limiting symptomatic conditions precluding satisfactory performance of duty. Aneurysm corrected by surgery but with residual limiting symptomatic conditions that preclude satisfactory performance of duty.
  - (a) Satisfactory performance of duty is precluded because of underlying recurring or progressive disease producing pain, dyspnea, or similar symptomatic limiting conditions.
    - 1 reconstructive surgery including grafts, when: prosthetic devices are attached to or implanted in the heart; and
    - 2 unproven procedures have been accomplished and the patient is unable to satisfactorily perform duty or cannot be returned to duty under circumstances permitting close medical supervision.
- (4) Periarteritis nodosa. With definite evidence of functional impairment.
- (5) Chronic venous insufficiency (postphlebotic syndrome). When more than mild and symptomatic despite elastic support.
- (6) Raynaud's phenomenon. Manifested by trophic changes of the involved part characterized by scarring of the skin or ulceration.
- (7) Thrombophlebitis. When repeated attacks require such frequent treatment as to interfere with satisfactory performance of duty.
- (8) Varicose veins. Severe and symptomatic despite therapy.
- (9) Any condition requiring anti-thrombotic medication other than aspirin.

c. Miscellaneous.

- (1) Erythromelalgia. Persistent burning pain in the soles or palms not relieved by treatment.
- (2) Hypertensive cardiovascular disease and hypertensive vascular disease.
  - (a) Diastolic pressure consistently more than 90 mm Hg following an adequate period of therapy on an ambulatory status; or
  - (b) Any documented history of hypertension regardless of the pressure values if associated with one or more of the following:
    - 1 cerebrovascular symptoms;



- 2 arteriosclerotic heart disease if symptomatic and requiring treatment;
  - 3 kidney involvement, manifested by unequivocal impairment of renal function; or
  - 4 grade III (Keith-Wagener-Barker) changes in the fundi.
- (3) Rheumatic fever, active, with or without heart damage. Recurrent attacks.
  - (4) Residual of surgery of the heart, pericardium, or vascular system under one or more of the following circumstances:
    - (a) when surgery of the heart, pericardium, or vascular system results in inability of the individual to perform duties without discomfort or dyspnea;
    - (b) when the surgery involves insertion of a pacemaker, reconstructive vascular surgery employing exogenous grafting material; or
    - (c) similar newly developed techniques or prostheses, the individual is unfit.

9. Abdomen and Gastrointestinal System.

a. Defects and Diseases.

- (1) Achalasia. Manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.
- (2) Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.
- (3) Biliary dyskinesia. Frequent abdominal pain not relieved by simple medication, or with periodic jaundice.
- (4) Cirrhosis of the liver. Recurrent jaundice or ascites; or demonstrable esophageal varices or history of bleeding therefrom.
- (5) Gastritis. Severe, chronic gastritis with repeated symptomatology and hospitalization and confirmed by gastroscopic examination.
- (6) Hepatitis, chronic. When, after a reasonable time (1 to 2 years) following the acute stage, symptoms persist, and there is objective evidence of impaired liver function.
- (7) Hernia.
  - (a) Hiatus hernia. Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.
  - (b) Other. If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.
- (8) Ileitis, regional. (Crohn's disease); Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.



- (9) Pancreatitis, chronic. Frequent severe abdominal pain; or steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.
- (10) Peritoneal adhesions. Recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent hospital admissions.
- (11) Proctitis, chronic. Moderate to severe symptoms of bleeding, or painful defecation, tenesmus, and diarrhea, with repeated hospital admissions.
- (12) Ulcer, peptic, duodenal, or gastric. Repeated incapacitation or absences from duty because of recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory, x-ray, and endoscopic evidence of activity.
- (13) Ulcerative colitis. Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.
- (14) Rectum, stricture of. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, difficult bowel movements requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

b. Surgery.

- (1) Colectomy, partial. When more than mild symptoms of diarrhea remain or if complicated by colostomy.
- (2) Colostomy. When permanent.
- (3) Enterostomy. When permanent.
- (4) Gastrectomy.
  - (a) Total.
  - (b) Subtotal, with or without vagotomy, or gastrojejunostomy, with or without vagotomy, when, in spite of good medical management, the individual:
    - 1 develops "dumping syndrome" that persists for 6 months postoperatively; or
    - 2 develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively; or
    - 3 continues to demonstrate significant weight loss 6 months postoperatively. Preoperative weight representative of obesity should not be taken as a reference point in making this assessment.



- 4 Not to be confused with "dumping syndrome," and not ordinarily considered as representative of unfitness are: postoperative symptoms such as moderate feeling of fullness after eating; the need to avoid or restrict ingestion of high carbohydrate foods; the need for daily schedule of a number of small meals with or without additional "snacks."
- (5) Gastrostomy. When permanent.
- (6) Ileostomy. When permanent.
- (7) Pancreatectomy.
- (8) Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejunostomy. Followed by more than mild symptoms of digestive disturbance, or requiring insulin.
- (9) Proctectomy.
- (10) Proctopexy, proctoplasty, proctorrhaphy, or proctotomy. If fecal incontinence remains after appropriate treatment.

10. Endocrine and Metabolic Conditions (Diseases).

- a. Acromegaly. With function impairment.
- b. Adrenal hyperfunction. That does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.
- c. Adrenal hypofunction. Requiring medication for control.
- d. Diabetes Insipidus. Unless mild, with good response to treatment.
- e. Diabetes Mellitus. When requiring insulin or not controlled by oral medications.
- f. Goiter. With symptoms of breathing obstruction with increased activity, unless correctable.
- g. Gout. With frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.
- h. Hyperinsulinism. When caused by a malignant tumor, or when the condition is not readily controlled.
- i. Hyperparathyroidism. When residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.
- j. Hyperthyroidism. Severe symptoms, with or without evidence of goiter, that do not respond to treatment.



- k. Hypoparathyroidism. With objective evidence and severe symptoms not controlled by maintenance therapy.
  - l. Hypothyroidism. With objective evidence and severe symptoms not controlled by medication.
  - m. Osteomalacia. When residuals after therapy preclude satisfactory performance of duty.
11. Genitourinary System.
- a. Genitourinary conditions.
    - (1) Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.
    - (2) Dysmenorrhea. Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than 1 day/month.
    - (3) Endometriosis. Symptomatic and incapacitating to degree that necessitates recurrent absences of more than 1 day/month.
    - (4) Hypospadias. Accompanied by chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings, and the condition is not amenable to treatment.
    - (5) Incontinence of urine. Due to disease or defect not amenable to treatment and so severe as to necessitate recurrent absences from duty.
    - (6) Menopausal syndrome, physiologic or artificial. With more than mild mental and constitutional symptoms.
    - (7) Strictures of the urethra or ureter. Severe and not amenable to treatment.
    - (8) Urethritis, chronic. Not responsive to treatment and necessitating frequent absences from duty.
  - b. Kidney.
    - (1) Calculus in kidney. Bilateral or symptomatic and not responsive to treatment.
    - (2) Congenital abnormality. Bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.
    - (3) Cystic kidney (polycystic kidney). When symptomatic and renal function is impaired, or if the focus of frequent infection.
    - (4) Glomerulonephritis, chronic.
    - (5) Hydronephrosis. More than mild, or bilateral, or causing continuous or frequent symptoms.
    - (6) Hypoplasia of the kidney. Associated with elevated blood pressure or frequent infections and not controlled by surgery.



- (7) Nephritis, chronic.
- (8) Nephrosis.
- (9) Perirenal abscess. With residuals that preclude satisfactory performance of duty.
- (10) Pyelonephritis or pyelitis. Chronic, that has not responded to medical or surgical treatment, with evidence of persistent hypertension, eyeground changes, or cardiac abnormalities.
- (11) Pyonephrosis. Not responding to treatment.

c. Genitourinary and Gynecological Surgery.

- (1) Cystectomy.
- (2) Cystoplasty. If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cc or if refractory symptomatic infection persists.
- (3) Nephrectomy. When, after treatment, there is infection or pathology in the remaining kidney.
- (4) Nephrostomy. If drainage persists.
- (5) Oophorectomy. When, following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.
- (6) Penis, amputation of.
- (7) Pyelostomy. If drainage persists.
- (8) Ureterocolostomy.
- (9) Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.
- (10) Ureterocystostomy, cutaneous.
- (11) Ureteroplasty.
  - (a) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for a nephrectomy.
  - (b) When bilateral, evaluate residual obstruction or hydronephrosis and consider unfitness on the basis of the residuals involved.
- (12) Ureterosigmoidostomy.
- (13) Ureterostomy. External or cutaneous.
- (14) Urethroostomy. When a satisfactory urethra cannot be restored.

12. Extremities.

d. Upper.

- (1) Amputations. Amputation of part or parts of an upper extremity equal to or greater than any of the following:



- (a) a thumb proximal to the interphalangeal joints;
  - (b) two fingers of one hand; or
  - (c) one finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.
- (2) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 1.
- (a) Shoulder.
    - 1 Forward elevation to  $90^{\circ}$  .
    - 2 Abduction to  $90^{\circ}$  .
  - (b) Elbow
    - 1 Flexion to  $100^{\circ}$  .
    - 2 Extension to  $60^{\circ}$  .
  - (c) Wrist. A total range, extension plus flexion, of  $15^{\circ}$
  - (d) Hand. For this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints.
    - 1 An active flexor value of combined joint motions of  $135^{\circ}$  in each of two or more fingers of the same hand.
    - 2 An active extensor value of combined joint motions of  $75^{\circ}$  in each of the same two or more fingers.
    - 3 Limitation of motion of the thumb that precludes apposition to at least two finger tips.
  - (3) Recurrent dislocations of the shoulder. When not repairable or surgery is contraindicated

e. Lower.

- (1) Amputations.
  - (a) Loss of a toe or toes that precludes the ability to run, or walk without a perceptible limp, or to engage in fairly strenuous jobs.
  - (b) Any loss greater than that specified above to include foot, leg, or thigh.
- (2) Feet.



- (a) Hallux valgus. When moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.
- (b) Pes Planus. Symptomatic more than moderate, with pronation on weight bearing that prevents wearing military shoes, or when associated with vascular changes.
- (c) Talipes cavus. When moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or that prevents wearing a military shoe.
- (3) Internal derangement of the knee. Residual instability following remedial measures, if more than moderate; or with recurring episodes of effusion or locking, resulting in frequent incapacitation.
- (4) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 2.
  - (a) Hip.
    - 1 Flexion to  $90^{\circ}$  .
    - 2 Extension to  $0^{\circ}$  .
  - (b) Knee.
    - 1 Flexion to  $90^{\circ}$  .
    - 2 Extension to  $15^{\circ}$
  - (c) Ankle.
    - 1 Dorsiflexion to  $10^{\circ}$
    - 2 Plantar Flexion to  $10^{\circ}$
- (5) Shortening of an extremity. Which exceeds two inches.

f. Miscellaneous.

- (1) Arthritis.
  - (a) Due to infection. Associated with persistent pain and marked loss of function with x-ray evidence and documented history of recurring incapacity for prolonged periods.
  - (b) Due to trauma. When surgical treatment fails or is contraindicated and there is functional impairment of the involved joint that precludes satisfactory performance of duty.



- (c) Osteoarthritis. Severe symptoms associated with impaired function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.
- (d) Rheumatoid arthritis or rheumatoid myositis. Substantiated history of frequent incapacitating and prolonged periods supported by objective and subjective findings.
- (e) Seronegative Spondylarthropathies. Severe symptoms associated with impaired function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.
- (2) Chondromalacia or Osteochondritis Dissecans. Severe, manifested by frequent joint effusion, more than moderate interference with function or with severe residuals from surgery.
- (3) Fractures.
  - (a) Malunion. When, after appropriate treatment, there is more than moderate malunion with marked deformity or more than moderate loss of function.
  - (b) Nonunion. When, after an appropriate healing period, the nonunion precludes satisfactory performance of military duty.
  - (c) Bone fusion defect. When manifested by more than moderate pain or loss of function.
  - (d) Callus, excessive, following fracture. When functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.
- (4) Joints.
  - (a) Arthroplasty. With severe pain, limitation of motion and function.
  - (b) Bony or fibrous ankylosis. Severe pain involving major joints or spinal segments in an unfavorable position, or with marked loss of function.
  - (c) Contracture of joint. Marked loss of function and the condition is not remediable by surgery.
  - (d) Loose bodies within a joint. Marked functional impairment complicated by arthritis that precludes favorable treatment or not remediable by surgery.
- (5) Muscles.



- (a) Flaccid paralysis of one or more muscles, producing loss of function that precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.
- (b) Spastic paralysis of one or more muscles producing loss of function that precludes satisfactory performance of duty.
- (6) Myotonia congenita.
- (7) Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.
- (8) Osteoarthropathy, hypertrophic, secondary. Moderately severe to severe pain present with joint effusion occurring intermittently in one or multiple joints and with at least moderate loss of function.
- (9) Osteomyelitis, chronic. Recurrent episodes not responsive to treatment, and involving the bone to a degree that interferes with stability and function.
- (10) Tendon transplant. Fair or poor restoration of function with weakness that seriously interferes with the function of the affected part.

13. Spine, Scapulae, Ribs, and Sacroiliac Joints.

- a. Congenital anomalies.
  - (1) Spina bifida. Demonstrable signs and moderate symptoms of root or cord involvement.
  - (2) Spondylolysis or spondylolisthesis. With more than mild symptoms resulting in repeated hospitalization or significant assignment limitation.
- b. Coxa vara. More than moderate with pain, deformity, and arthritic changes.
- c. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remediable measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.
- d. Kyphosis. More than moderate, or interfering with function, or causing unmilitary appearance.
- e. Scoliosis. Severe deformity with over two inches of deviation of tips of spinous processes from the midline.

14. Skin and Cellular Tissues.

- a. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.
- b. Atopic dermatitis. More than moderate or requiring periodic hospitalization.
- c. Amyloidosis. Generalized.



- d. Cysts and tumors. See section 3-F-20.
- e. Dermatitis herpetiformis. Which fails to respond to therapy.
- f. Dermatomyositis.
- g. Dermographism. Interfering with satisfactory performance of duty.
- h. Eczema, chronic. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.
- i. Elephantiasis or chronic lymphedema. Not responsive to treatment.
- j. Epidermolysis bullosa.
- k. Erythema multiforme. More than moderate and chronic or recurrent.
- l. Exfoliative dermatitis. Chronic.
- m. Fungus infections, superficial or systemic. If not responsive to therapy and interfering with the satisfactory performance of duty.
- n. Hidradenitis suppurative and folliculitis decalvans.
- o. Hyperhydrosis. Of the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.
- p. Leukemia cutis and mycosis fungoides.
- q. Lichen planus. Generalized and not responsive to treatment.
- r. Lupus erythematosus. Chronic with extensive involvement of the skin and mucous membranes and when the condition does not respond to treatment.
- s. Neurofibromatosis. If repulsive in appearance or when interfering with satisfactory performance of duty.
- t. Panniculitis. Relapsing febrile, nodular.
- u. Parapsoriasis. Extensive and not controlled by treatment.
- v. Pemphigus. Not responsive to treatment, and with moderate constitutional or systemic symptoms, or interfering with satisfactory performance of duty.
- w. Psoriasis. Extensive and not controllable by treatment.
- x. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.



- y. Scars and keloids. So extensive or adherent that they seriously interfere with the function of an extremity.
  - z. Scleroderma. Generalized, or of the linear type that seriously interferes with the function of an extremity or organ.
  - aa. Ulcers of the skin. Not responsive to treatment after an appropriate period of time or if interfering with satisfactory performance of duty.
  - bb. Urticaria. Chronic, severe, and not amenable to treatment.
  - cc. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.
  - dd. Other skin disorders. If chronic, or of a nature that requires frequent medical care or interferes with satisfactory performance of military duty.
15. Neurological Disorders.
- a. Amyotrophic sclerosis, lateral.
  - b. Atrophy, muscular, myelopathic. Includes severe residuals of poliomyelitis.
  - c. Atrophy, muscular. Progressive muscular atrophy.
  - d. Chorea. Chronic and progressive.
  - e. Convulsive disorders. (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) Following a seizure, the member is NFFD, and will remain unfit until he/she is controlled with medications with no seizures for twelve months. A medical board is not required if the convulsive disorder is well controlled.
  - f. Friedreich's ataxia.
  - g. Hepatolenticular degeneration.
  - h. Migraine. Manifested by frequent incapacitating attacks or attacks that last for several consecutive days and unrelieved by treatment.
  - i. Multiple sclerosis.
  - j. Myelopathy transverse.
  - k. Narcolepsy, cataplexy, and hypersomnolence.
  - l. Obstructive Sleep Apnea. when not correctable by use of CPAP or surgical means.
  - m. Paralysis, agitans.



- n. Peripheral nerve conditions.
    - (1) Neuralgia. When symptoms are severe, persistent, and not responsive to treatment.
    - (2) Neuritis. When manifested by more than moderate, permanent functional impairment.
  - o. Syringomyelia.
  - p. General. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance loss of consciousness, speech or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.
16. Psychiatric Disorders. (see section 5-B concerning disposition)
- a. Disorders with Psychotic Features. Recurrent psychotic episodes, existing symptoms or residuals thereof, or recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.
  - b. Affective disorders; anxiety, somatoform, or dissociative disorders. Persistence or recurrence of symptoms sufficient to require treatment (medication, counseling, psychological or psychiatric therapy) for greater than 6 months. Regardless of the length of treatment, any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see "Personnel Manual, COMDTINST M1000.6 (series) for further guidance".
  - c. Mood disorders. Bipolar disorders or recurrent major depression. All other mood disorders associated with suicide attempt, untreated substance abuse, requiring hospitalization or requiring treatment (including medication, counseling, psychological or psychiatric therapy) for more than 6 months, or requiring more than 36 months of prophylactic treatment (while asymptomatic) following initial therapy. Prophylactic treatment requiring more than one drug associated with significant side effects (such as sedation, dizziness or cognitive changes) or frequent follow-up that limit duty options. Any member requiring medication for any of the above disorders must be removed from aviation duty, but may request waiver from CGPC. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see "Personnel Manual, COMDTINST M1000.6 (series) for further guidance."
  - d. Personality; sexual; factitious; psychoactive substance use disorders; personality trait(s); disorders of impulse control not elsewhere classified. These conditions may render an individual administratively unfit rather than unfit because of a physical impairment. Interference with performance of effective duty will be dealt with through appropriate administrative channels (see section 5-B).



- e. Adjustment Disorders. Transient, situational maladjustment due to acute or special stress does not render an individual unfit because of physical impairment. However, if these conditions are recurrent and interfere with military duty, are not amenable to treatment, or require prolonged treatment, administrative separation should be recommended (see Section 5-B).
  - f. Disorders usually first evident in infancy, childhood, or adolescence, disorders of intelligence. These disorders, to include developmental disorders, may render an individual administratively unfit rather than unfit because of a physical impairment. Anorexia Nervosa and Bulimia are processed through PDES, while the remaining are handled administratively, if the condition significantly impacts, or has the potential to significantly impact performance of duties (health, mission, and/or safety). See section 5-B of this Manual and Chapter 12 of the personnel manual for further guidance.
17. Dental. Diseases and abnormalities of the jaws or associated tissues when, following restorative surgery, there remain residual conditions that are incapacitating or interfere with the individual's satisfactory performance of military duty, or deformities that are disfiguring. Personnel must be in a Class 1 or Class 2 dental status (see figure 3-C-2) to execute sea duty or overseas duty orders. Prior service personnel must meet the enlistment dental standards contained in section 3-D.
18. Blood and Blood-Forming Tissue Diseases. When response to therapy is unsatisfactory, or when therapy requires prolonged, intensive medical supervision.
- a. Anemia.
  - b. Hemolytic disease, chronic and symptomatic.
  - c. Leukemia, chronic.
  - d. Polycythemia.
  - e. Purpura and other bleeding diseases. Any condition requiring long-term coumadin.
  - f. Thromboembolic disease.
  - g. Splenomegaly, chronic.
19. Systemic Diseases, General Defects, and Miscellaneous Conditions.
- a. Systemic Diseases.
    - (3) Blastomycosis.
    - (4) Brucellosis. Chronic with substantiated recurring febrile episodes, severe fatigability, lassitude, depression, or general malaise.
    - (5) Leprosy. Any type.
    - (6) Myasthenia gravis.



- (7) Porphyria Cutanea Tarda.
- (8) Sarcoidosis. Progressive, with severe or multiple organ involvement and not responsive to therapy.
- (9) Tuberculosis (TB).
  - (a) Meningitis, tuberculosis.
  - (b) Pulmonary TB, tuberculous empyema, and tuberculous pleurisy.
  - (c) TB of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.
  - (d) TB of the female genitalia.
  - (e) TB of the kidney.
  - (f) TB of the larynx.
  - (g) TB of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery will be evaluated on an individual basis considering the associated involvement, residuals, and complications.

b. General Defects.

- (1) Visceral, abdominal, or cerebral allergy. Severe or not responsive to therapy.
- (2) Cold injury. Evaluate on severity and extent of residuals, or loss of parts as outlined in section 3-F-12.

c. Miscellaneous Conditions.

- (1) Chronic Fatigue Syndrome, Fibromyalgia , and Myofascial Syndrome when not controlled by medication or with reliably diagnosed depression.

d. Conditions that individually or in combination, not elsewhere provided for in this section, if:

- (1) the individual is precluded from a reasonable fulfillment of the purpose of employment in the military service; or
- (2) the individual's health or well-being would be compromised if allowed to remain in the military service; or
- (3) the individual's retention in the military service would prejudice the best interests of the Government.
- (4) required chronic and continuous DEA controlled (Class I-V) medications, such as Ritalin, Amphetamine, Cylert, Modafanil.
- (5) required chronic anti-coagulant, other than aspirin, such as Coumadin.



20. Tumors and Malignant Diseases.

- a. Malignant Neoplasms. Which are unresponsive to therapy or when the residuals of treatment are in themselves disqualifying under other provisions of this section or in individuals on active duty when they preclude satisfactory performance of duty.
- b. Neoplastic Conditions of Lymphoid and Blood Forming Tissues. Render an individual unfit for further military service.
- c. Benign Neoplasms. Except as noted below, benign neoplasms are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment are unfit only if their condition precludes satisfactory performance of military duty. However, the following normally render the individual unfit for further military service:
  - (1) Ganglioneuroma; or
  - (2) Meningeal fibroblastoma. When brain is involved.

21. Sexually Transmitted Disease.

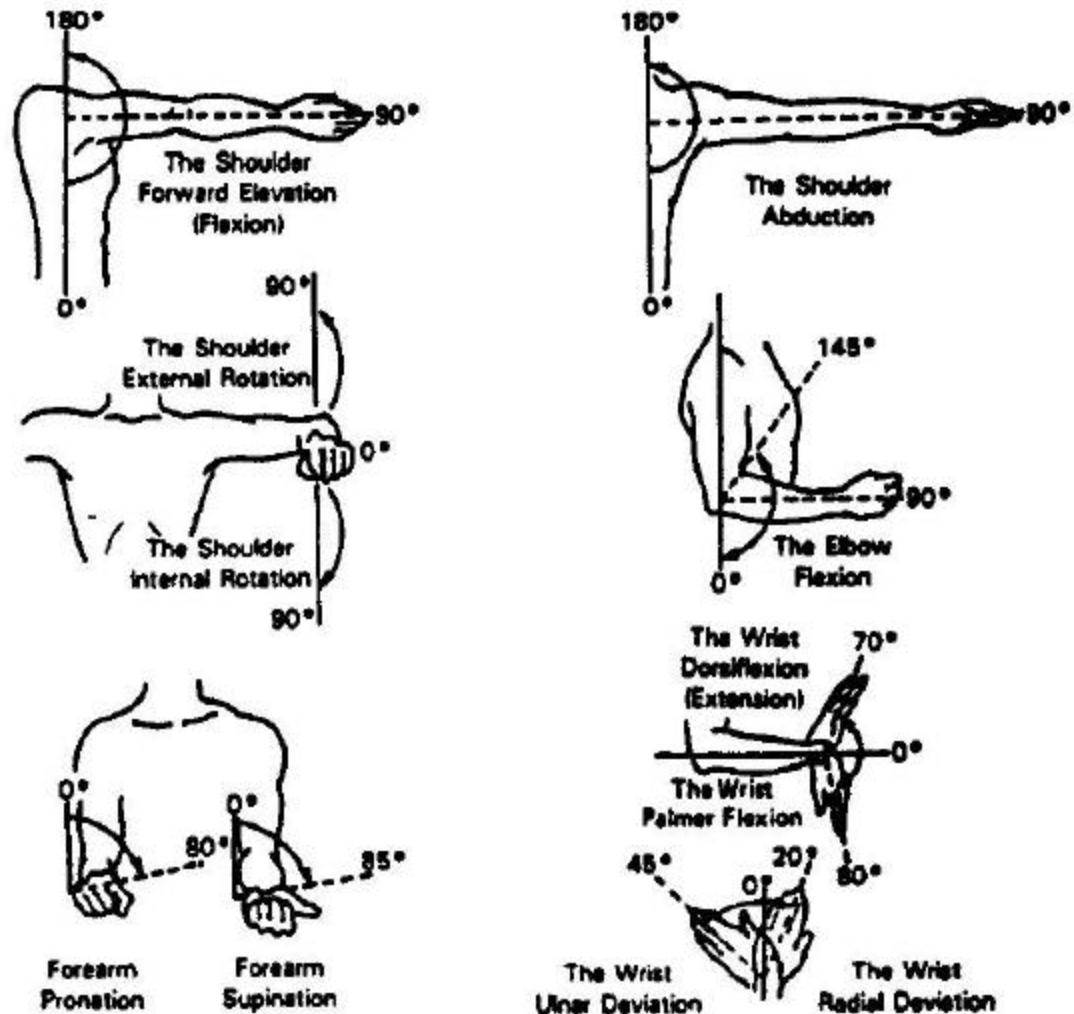
- a. Symptomatic neurosyphilis. In any form.
- b. Complications or residuals. Of venereal diseases of such chronicity or degree of severity that the individual is incapable of performing useful duty.

22. Human Immunodeficiency Virus (HIV). An Initial Medical Board will be convened on all members who are diagnosed as HIV antibody positive. Members who are HIV antibody positive, but are otherwise asymptomatic, are not eligible for worldwide deployment but may remain on active duty in a non-deployable billet. Those members who remain asymptomatic must have a Disposition Medical Board prior to separation. Members who are HIV antibody positive and demonstrate immunologic deficiency, neurologic involvement, progressive clinical or laboratory abnormalities associated with HIV, as well as those diagnosed as having aids related complex or acquired immunodeficiency syndrome are disqualified for reenlistment and retention.

23. Transplant recipient. Any organ or tissue except hair or skin.



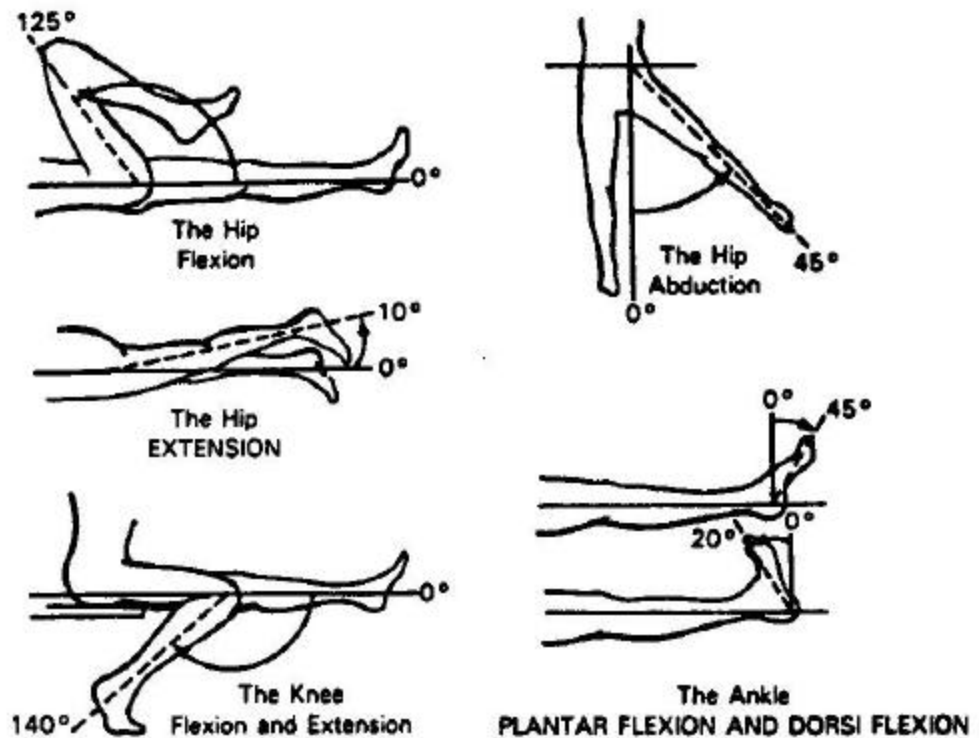
**3-F - EXHIBIT 1**  
**MEASUREMENT OF ANKYLOSIS AND JOINT MOTION**  
**UPPER EXTREMITIES**



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90°, the forearm is in mid position (0°) between pronation and supination when the thumb is uppermost.



**3-F — EXHIBIT 2**  
**MEASUREMENT OF ANKYLOSIS AND JOINT MOTION**  
**LOWER EXTREMITIES**



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the lower extremities. The anatomical position is considered as 0°.



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## Section G Physical Standards for Aviation

### 1. Classification of Aviation Personnel.

- a. Aviation Personnel in General. Classification of Coast Guard aviation personnel is similar to that prescribed for Navy aviation personnel. The term "aviation personnel" includes all individuals who, in the performance of their duty, are required to make frequent aerial flights. Aviation personnel are divided into two classes: Class 1 and Class 2.
- b. Class 1. Class 1 consists of aviation personnel engaged in actual control of aircraft, which includes aviators, student aviators, and student flight surgeons that are chosen to perform solo flights.
- c. Class 1R. Class 1R consists of aviation personnel engaged in actual control of aircraft who:
  - (1) meet Class 1 standards but are age 50 or over; or
  - (2) have a waiver (temporary or permanent) of physical standards which forbids unrestricted flight. The flight restriction(s) to which the Class 1R pilot is subject will be defined by the waiver authority. In all cases, however, Class 1R aviators will fly as a dual pilot with a Class 1 aviator.
- d. Changing Classes. Except for changes in class due solely to age, individuals requiring a change in their classification for more than two months must submit the following to Commander CGPC:
  - (1) SF-502, Narrative Summary, completed by a flight surgeon/aviation medical officer stating the need for the class change and whether a permanent or temporary change is requested; and
  - (2) command endorsement.
- e. Class 2. Class 2 consists of aviation personnel not engaged in actual control of aircraft. This includes aviation observers, technical observers, flight surgeons, aviation medical officers, aviation MEDEVAC specialists, flight officers, aircrew members, air traffic controllers, and other persons ordered to duty involving flying.

### 2. General Instructions for Aviation Examinations.

- a. Object of Aviation Physical Examinations.
  - (1) The examination for flying shall be limited to members of the aeronautical organization and authorized candidates. The object of an aviation physical examination is to ensure individuals involved in aviation are physically and mentally qualified for such duty, and to remove from aviation those who are temporarily or permanently unfit because of physical or mental defect.



- (2) The main objective in examining candidates for flight training is selecting individuals who can fly safely and continue to do so for at least 20 years.
  - (3) For designated aviators, the objective is to determine if the individual can fly safely during the next 24 months.
- b. Performance of Aviation Physical Examinations. To promote safety and to provide uniformity and completeness, an aviation physical examination must be performed by a currently qualified flight surgeon/aviation medical officer (AMO) authorized by the Commandant. Only physicians who have successfully passed a course at a school of aviation medicine of the U. S. Armed Forces leading to the designation of "Aviation Medical Officer" or "Flight Surgeon" are so authorized. Civilian physicians who were military flight surgeons and who are currently certified by the Federal Aviation Administration as aviation medical examiners may also be authorized.
- c. Scope of Aviation Physical Examination. In addition to the general service requirements specified in section 3-D, certain special requirements must be met by the various categories of individuals concerned with aviation. The extent of the examination and the physical standards vary for the several categories of aviation personnel. The term "flight or aviation physical examination" is therefore incomplete unless the character of the duty that the examinee is to perform is specified--this incomplete term shall not be used in item #16 of SF 88 (rev 10-94) as the purpose of the examination. Examiners shall conduct aviation physical examinations in accordance with the general procedures specified in this section and in section 3-C.
- d. Required Aviation Physical Examinations. Each individual in the Service who is assigned to duty requiring performance of frequent aerial flights, regardless of classification, must have passed an aviation physical within the preceding 24 months. In some cases, more frequent examinations are required. Aviation physical examinations are required as indicated in this section. They may also be ordered whenever needed to determine an individual's physical fitness for the type aviation duty to which assigned.
  - (1) Entry on Active Duty. Reserve aviation personnel who perform frequent aerial flights must have passed an aviation physical examination, commensurate with the type of duty to be performed, within the 24 months preceding active duty or active duty for training. Aviators who are not members of aviation reserve units must have satisfactorily passed an aviation physical examination within six months immediately preceding the actual control of aircraft.
  - (2) Biennial. All aviation personnel, including Reservists on inactive duty for training, who will actually control aircraft or perform frequent aerial flights must obtain a biennial aviation physical examination commensurate with the type of duty to be performed. The examination is required every two (2) years after initial designation. Upon reaching age 50, the examinations become annual.



- (3) Direct Commission. An aviation physical examination is required prior to direct commissioning of aviators in the Reserve. The aviator is required to meet Class I standards.
  - (4) Candidates for Designation as Class 1. All candidates for flight training, whether or not they are already in the Service, must pass a physical examination for flight training duty. The examination date must not precede the application date by more than 12 months.
  - (5) Candidates for Designation as Class 2. An approved aviation physical examination less than 24 months old is required both when applying for a Class 2 aviation training program and prior to a Class 2 designation.
  - (6) FAA Airmen Medical Certificate. After receiving Federal Aviation Administration (FAA) Aviation Medical Examiner (AME) training, Coast Guard flight surgeons/AMOs may request authorization from Commandant (G-WKH) to perform Second and Third Class physical examinations and issue FAA Medical Certificates to all military personnel on active duty including active duty for training. The FAA Administrator furnishes AME's with the necessary instructions, guides, and forms required for this purpose. Except in those instances where there is a military requirement for FAA certification, examination and issuance of medical certificates shall not interfere with the flight surgeon's primary duties. Whenever possible, certificates should be obtained in conjunction with a required aviation physical examination.
  - (7) Aircraft Accidents. Any Coast Guard member involved in a Class A or B aircraft mishap in which damage to the aircraft or injury to any crewmember occurs shall undergo a complete aviation physical examination as part of the mishap investigation. Examinations after other mishaps are left to the discretion of the flight surgeon/AMO.
  - (8) Quinquennial. The quinquennial examination of a Reserve aviation special duty officer must be an aviation physical examination.
  - (9) Separation. An aviation physical examination is not required of aviation personnel being separated from active duty. The requirements for examination are the same as those for the separation from active duty of non-aviation personnel.
- e. Boards. Assignment to and continuation of duty involving flying is an administrative process. Except for enlisted personnel in aviation ratings, fitness to perform aviation duties is a determination independent of the determination of fitness for continued service.
- (1) Board of Flight Surgeons. When a fitness for continued service determination is not required or in cases where the disposition is appropriately administrative [e.g., a condition not a ratable disability or covered under sections 12-A or 4-C of the Personnel Manual, COMDTINST M1000.6 (series)] a Board of Flight Surgeons shall be convened. The board shall consist of two medical officers, one of whom must be a flight surgeon or AMO. When formation of such a board is not feasible, a single flight surgeon/AMO may be considered the



minimum with the approval of Commandant (G-WKH). An example of the appropriate use of a Board of Flight Surgeons is an aviator found not aeronautically adaptable due to fear of flying. The results of the board shall be recorded on a Narrative Summary (SF-502) and submitted to Commander CGPC via the appropriate chain of command.

(2) Special Board of Flight Surgeons.

- (a) The U.S. Navy has established this board to consider unusual, complicated, or controversial cases beyond the capabilities or experience level of a local Board of Flight Surgeons. The Naval Aerospace Medical Institute (NAMI) is staffed and equipped to evaluate such cases. Special Boards must be arranged through Commandant (G-WKH).
- (b) NAMI specialists may be requested as consultants without convening a full Special Board. Specialty consultations may be requested and arranged by local command.

f. Reporting Fitness for Flying Duties.

- (1) Aviation personnel admitted to the sicklist or hospitalized shall be suspended from all duty involving flying. Upon the recommendation of a medical officer (not restricted to a flight surgeon/aviation medical officer), the commanding officer may relieve from flying duty or suspend the flight training of an individual deemed unfit for such duty. In all instances, a Grounding Notice (Aero-Medical NAVMED 6410/1) shall be issued.
- (2) When aviation personnel are subsequently deemed fit to resume flying duties, they shall be examined by a flight surgeon/aviation medical officer and a Clearance Notice (Aero-Medical NAVMED 6410/2) shall be submitted to the commanding officer. Based on this recommendation, the commanding officer may authorize resumption of such duty or training.
- (3) Class 1 or 2 aviation personnel, upon reporting to a new duty station or upon returning from an extended absence from flying duty for any reason or when otherwise indicated, shall be interviewed by a flight surgeon/aviation medical officer in order to determine their current health, verify that a current aviation physical examination has been conducted, and to administratively review their health record. If the flight surgeon/aviation medical officer deems it appropriate, a physical examination may be conducted to determine their physical fitness to continue or resume their flying duties. The appropriate Grounding or Clearance Notice shall be completed in all such cases and the necessary notation made in the individual's health record on an SF-600. Specific guidance for some special circumstances are:
  - (a) Post-hospitalization. A post-hospitalization examination may be required.



- (b) Alcohol Abuse. Members under aviation class 1 or 2 retention standards involved in alcohol related incidents or who are referred for alcohol screening shall be recommended for grounding. If, after alcohol screening, a specific medical diagnosis of Alcohol Abuse (305.00 DSM III-R) or Alcohol Dependence (303.90 DSM III-R) cannot be made, the individual can be returned to aviation duties without a formal waiver. Those aviation personnel who are diagnosed as Alcohol Abusers or Alcohol Dependent can return to duties involving flight only after favorable action by the appropriate waiver authority. In addition, class 2 aircrewmembers with either of these diagnoses must be cleared by the flight surgeon/AMO before returning to flight-line duties or activities involving aircraft maintenance. Candidates for Student Naval Aviator or Aircrew Candidates with a history of alcohol dependence or abuse will be considered for a waiver after successful rehabilitation (outpatient or inpatient) and an interval of aftercare (1 year for dependence and 90 days for abuse) dating from the onset of rehabilitation.

1 The waiver request must include:

- a The flight surgeon's Narrative Summary (SF 502);
- b How the problem was identified;
- c Drinking history: When subject member first drank, history of DUIs, blackouts, frequent sick-call visits, withdrawal symptoms, morning drinking, domestic difficulties, impaired job performance, etc.;
- d Lab data (LFTs, red cell indices, etc.);
- e Any Narrative Summary from rehabilitation authority;
- f Commanding officer's endorsement in accordance with paragraph 3-A-8.d.(2). This must include details of any mandated aftercare plan.

2 The waiver process should not be initiated until the aviation member:

- a Completes Level II or III rehabilitation program or the civilian equivalent;
- b Demonstrates compliance with their aftercare program for at least three months.

3 Waiver contingencies will usually incorporate the recommendations of the rehabilitation authority and may include one or more of the following:

- a Total abstinence;
- b Active participation in a sobriety program (which includes AA);



- c Follow-up by the flight surgeon at least quarterly for a year then at least annually thereafter.

(c) Pregnancy. After confirmation of pregnancy, female members should not be assigned to duties involving flight until cleared by her flight surgeon (FS)/aviation medical officer (AMO). Nausea, decreased appetite, easy fatigability, dizziness, and vaginal bleeding are some of the potential problems that may cause the FS/AMO to recommend temporary grounding for pregnant aviation personnel. Close monitoring is required by the FS/AMO to ensure early identification of problems associated with pregnancy, that could be hazardous to the pregnant member or others. In addition, the FS/AMO will assess the ergonomic and toxic hazards to which the pregnant member and her fetus may be exposed in her particular aviation environment. Potential occupational health problems will be brought to the attention of the patient and the command. No member will perform duties as a rescue swimmer upon confirmation of pregnancy. No pregnant member shall perform duties involving flying after the end of the second trimester, nor shall they undergo chamber (physiologic) training or training involving swimming after the end of the second trimester. (Note: Any pregnant member undergoing chamber or dunker training must receive, from a flight surgeon or AMO, a status profile chit indicating she is "OK DIF/Dunker/Chamber.")

(4) Areas without flight surgeons/AMOs assigned or when the assigned flight surgeon/AMO is on leave or TAD:

- (a) The authority to issue a Grounding Notice includes all medical officers, dental officers, and health service technicians.
- (b) Flight surgeons (FS) and aviation medical officers (AMO) are the only personnel authorized to issue clearance notices (ie. Up chits) for the resumption of flight duties. In the absence of an assigned flight surgeon, MOs, DOs, and HSs may issue a clearance notice related to the scope of the specialty of the provider after concurrence has been received from an FS or AMO. Concurrence can be obtained by either message or verbal communication. Clearance notices issued by an MO, DO, or HS must include the name, rank, and duty station of the authorizing FS/AMO as well as the time and date of communication for authorization.
- (c) Channels of communication between commands without flight surgeons/AMOs and the nearest USMTF with a flight surgeon will be established to facilitate concurrence prior to issuing a clearance notice.

g. Reporting Aviation Physical Examinations.

- (1) Definition of "Physically Qualified".



- (a) Class 1 aviation personnel have passed an aviation physical examination when a flight surgeon/aviation medical officer or Board of Flight Surgeons finds that, according to the standards prescribed in this Manual, the examinee is physically qualified and aeronautically adapted for actual control of the aircraft, and has been approved by appropriate Reviewing Authority.
- (b) Class 2 aviation personnel have passed an aviation physical examination when a flight surgeon or physical evaluation board including a flight surgeon finds that, according to the standards prescribed in this Manual, the examinee is physically qualified and aeronautically adapted for flying, and has been approved by appropriate Reviewing Authority.
- (2) Aeronautical Adaptability. After the examination has been completed, the examiner shall review all the available information and make an assessment of the individual's qualifications for the type of flying duty to be performed. Generally, clinical syndromes except adjustment disorders should lead to a finding of "not physically qualified." Adjustment disorders, psychological factors affecting physical condition and conditions not attributable to a mental disorder that are a focus of attention or treatment and Axis II conditions (personality traits and disorders) as a primary diagnosis should lead to a finding of "physically qualified but not aeronautically adapted."
- (3) Comments and Recommendations. Examiners are encouraged to use the space on the SF-88 entitled "Remarks" or "Notes." In this space, the examiner may express an opinion on specific defects and the examinee's overall capabilities. Comments by the examinee or the examinee's immediate superior are occasionally most valuable, especially when removal from flight status is recommended. Examiners shall enclose such comments in writing as an addendum to the formal report whenever such information is considered relevant to making a final recommendation.

### 3. Restrictions Until Physically Qualified.

#### a. Restrictions by Reviewing Authority.

- (1) Except as authorized in this section, no person shall assume initial duty involving the actual control of aircraft until notification has been received from Commandant (G-WKH) that such person is physically qualified for that duty.
- (2) Pending receipt of the endorsed copy of the SF-88 or other communication from Commandant (G-WKH) or MLC(k) that the report of routine biennial physical examination has been approved, aviation personnel are physically qualified and aeronautically adapted for flight duty if a flight surgeon certifies that the individual has no physical or mental defect that is disqualifying.
- (3) When any member on flight status has been restricted by the Commandant (G-WKH) or MLC(k), such restriction remains technically in effect until it is changed by the same authority. However, in order to avoid delay in the return to flight status of those clearly qualified to perform such duties, commanding



officers are authorized, after consideration of a favorable recommendation made to Commandant (G-WKH) by a flight surgeon, to waive this technical restriction pending the action of the Commandant.

b. Restriction by Commanding Officer.

- (1) Upon recommendation by any medical officer or other health services department personnel, the commanding officer may relieve from flying duty or suspend the flight training of any individual reported physically incapacitated for such duty or suspend the flight training of any individual reported physically incapacitated for such duty. When the individual is subsequently reported physically fit by a flight surgeon, the commanding officer may authorize resumption of such duty or training.
- (2) Aviation personnel may be continued in a flying status pending correction of minor defects such as obtaining new eyewear prescriptions or dental restorations with the concurrence of a flight surgeon. When corrective action is completed, an entry shall be made in Item 72 of the SF-88 and the physical then forwarded for review.

4. Standards for Class 1.

a. General. The physical examination and physical standards for Class 1 are the same as those prescribed in sections 3-C and 3-D of this Manual, as modified by the following subparagraphs.

b. History.

- (1) History of any of the following is disqualifying: seizures, isolated or repetitive (grand mal, petit mal, psychomotor, or Jacksonian); head injury complicated by unconsciousness in excess of 12 hours or post traumatic amnesia or impaired judgment exceeding 48 hours; malaria, until adequate therapy has been completed and there are no symptoms while off all medication for 3 months.
- (2) For persons already in the Coast Guard a complete review of their health record is most important. Flight surgeons are authorized to postpone the examination of persons who fail to present their health record at the time of examination. In exercising this prerogative, due consideration must be made in cases where access to the individual's health record is administratively impracticable.

c. Therapeutics and General Fitness. Note on the SF-88 if the individual received medication or other therapeutic procedures within 24 hours of the examination. In general, individuals requiring therapeutics or who have observed lowering of general fitness (dietary, rest, emotional, etc.,) which might affect their flying proficiency shall not be found qualified for duty involving flying.

d. Height. Minimum 157.4 cm (62 inches). Maximum 198 cm (78 inches).



- e. Chest. Any condition that serves to impair respiratory function may be cause for rejection. Pulmonary function tests are recommended to evaluate individuals with a history of significant respiratory system problems.
- f. Cardiovascular System. Cardiac arrhythmia, heart murmur, or other evidence of cardiovascular abnormalities shall be carefully studied. Evidence of organic heart disease, rhythm disturbances or vascular diseases, if considered to impair the performance of flying duties, is cause for rejection.
- g. Teeth. The following are disqualifying:
  - (1) Any carious teeth that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.
  - (2) Any dental defect that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.
  - (3) Fixed active orthodontic appliances require a waiver from CGPC (opm or epm). (fixed retainers are exempt).
  - (4) Routine crown and temporary dental work is not disqualifying for aviation missions. Recommend that temporary crowns be cemented with permanent cement like polycarboxylate or zinc oxyphosphate cement until the permanent crown is delivered. Recommend temporary grounding of 6-12 hours after procedures. Such work may be disqualifying for deployment.
- h. Distant Visual Acuity. Distant visual acuity shall be not less than 20/200 in either eye and if less than 20/20 must be correctable to 20/20 with standard lenses. When the visual acuity of either eye is less than 20/20 correction shall be worn at all times while flying.
- i. Oculomotor Balance. The following are disqualifying:
  - (1) esophoria greater than 10 prism diopters;
  - (2) exophoria greater than 10 prism diopters;
  - (3) hyperphoria greater than 1.5 prism diopters;
  - (4) prism divergence at 20 feet and 13 inches is optional. These tests shall be accomplished only on designated aviators who have sustained significant head injury, central nervous system disease, or who have demonstrated a change in their phorias.
- j. Eyes. Any pathologic condition that may become worse or interfere with proper eye function under the environmental and operational conditions of flying disqualifies. History of radial keratotomy is disqualifying.
- k. Near Visual Acuity. Uncorrected near vision (both eyes) shall be not less than 20/200 correctable to 20/20, with correction worn in multivision lenses while flying if uncorrected near vision is less than 20/40 in either eye.



- l. Color Vision. Normal color perception is required.
  - m. Depth Perception. Normal depth perception is required. When any correction is required for normal depth perception it must be worn at all times.
  - n. Field of Vision. The field of vision for each eye shall be normal as determined by the finger fixation test. When there is evidence of abnormal contraction of the field of vision in either eye, the examinee shall be subjected to perimetric study for form. Any contraction of the form field of 15° or more in any meridian is disqualifying.
  - o. Refraction. There are no refractive limits.
  - p. Ophthalmoscopic Examination. Any abnormality disclosed on ophthalmoscopic examination that materially interferes with normal ocular function is disqualifying. Other abnormal disclosures indicative of disease, other than those directly affecting the eyes, shall be considered with regard to the importance of those conditions.
  - q. Ear. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. A perforation or evidence of present inflammation is disqualifying. The presence of a small scar with no hearing deficiency and no evidence of inflammation, does not disqualify. Perforation, or marked retraction of a drum membrane associated with chronic ear disease, is disqualifying.
  - r. Sickle Cell Preparation Test. Quantitative hemoglobin electrophoreses greater than 40% HGs is disqualifying.
5. Standards for Class 1R. Physical requirements for service are the same as for Class 1, except:
    - a. Age 50 or older, or
    - b. Have a waiver (temporary or permanent) of physical standards that forbids unrestricted flight.
  6. Candidates for Flight Training.
    - a. Standards. Candidates for flight training shall meet all the requirements of Class 1, with the following additions or limitations:
      - (1) Height. Candidates for Class I training must also satisfy the following anthropometric requirements: Refer to figure 3-G-1 through figure 3-G-4 for guidelines on measurements.
        - (a) **sitting height**: 33 inches to 40.9 inches. Record in parentheses in Item 42, SF-88 (SH\_\_\_\_), see figure 3-G-1 for proper measurements;
        - (b) **sitting eye height**: 28.5 inches or greater. Record in parentheses in Item 42, SF-88 (SEH\_\_\_\_), see figure 3-G-2 for proper measurements;



- (c) **thumb tip reach:** 28.5 inches or greater. Record in parentheses in Item 42, SF-88 (TTR\_\_\_\_), see figure 3-G-3 for proper measurements;
  - (d) **buttock-knee length:** 21 inches to 27.9 inches. Record in parentheses in Item 42, SF-88 (BKL\_\_\_\_), see figure 3-G-3 for proper measurements;
  - (e) **add:** sitting eye height (SEH) and thumb tip reach (TTR), 57 inches or greater. Record in parentheses in Item 42, (SEH + TTR =\_\_\_\_).
- (2) Uncorrected distant visual acuity must be not less than 20/50 each eye and correctable 20/20 each eye. Uncorrected near visual acuity must be not less than 20/20 each eye (may be waiverable).
- (3) While under the effects of a cycloplegic, the candidate must read 20/20 each eye. The following are disqualifying:
- (a) total myopia greater than (minus) -2.00 diopters in any meridian;
  - (b) total hyperopia greater than (plus) +3.00 diopters in any meridian;
  - (c) astigmatism greater than (minus) -0.75 diopters; (Report the astigmatic correction in terms of the negative cylinder required.)
  - (d) the purpose of this cycloplegic examination is to detect large latent refractive errors that could result in a change of classes during an aviation career. Therefore, the maximum correction tolerated at an acuity of 20/20 shall be reported. Cycloplegics reported as any other acuity, e.g., 20/15 will be returned.
- (4) Hearing. Audiometric loss in excess of the limits set forth in the following table is disqualifying:

|            |     |      |      |      |      |
|------------|-----|------|------|------|------|
| FREQUENCY  | 500 | 1000 | 2000 | 3000 | 4000 |
| EITHER EAR | 30  | 25   | 25   | 45   | 55   |

- (5) Personality. Must demonstrate, in an interview with the flight surgeon, a personality make-up of such traits and reaction that will indicate that the candidate will successfully survive the rigors of the flight training program and give satisfactory performance under the stress of flying.
- (6) Chest x-ray. Aviation trainees must have had a chest x-ray within the past three years.
- (7) Report of Medical History (SF-93). In addition to the normal completion of the SF-93, the following statement shall be typed in block 8 and signed by the applicant: "I certify that I do not now use, nor have I ever used, contact lens for any purpose, and that I am not aware that my uncorrected vision has ever been less than 20/40." If the applicant cannot sign this statement, include a full explanation by the examining flight surgeon, and an ophthalmology consultation.



b. Reporting.

- (1) The importance of the physical examination of a candidate should be recognized not only by the examining flight surgeon but also by health services personnel assisting in the procedure and preparing the report. Candidates often come from a great distance or from isolated ships. If the examination cannot be completed in one working day, seek the commanding officer's help in making it possible for the candidate to remain available for a second working day. Careful planning should keep such cases to a minimum. If a report, upon reaching Commandant (G-WKH), is found to be incomplete and must be returned, the candidate will suffer undue delay in receiving orders and in some cases will be completely lost to the Coast Guard as a candidate. The preparation of the SF-88 in the case of a candidate requires extreme care by all concerned.
- (2) In a report of the examination of a candidate, rigid adherence to set standards is expected. The examining officers are encouraged to use freely that portion of the report that provides for "remarks" or "notes." Comments made under "remarks" are the examiner's opinion. Information from any source may be molded into an expression of professional opinion. A final recommendation of the examiner must be made. When such recommendation is not consistent with standards set by Commandant (G-K) the examiner shall note that fact on the form under "remarks" or "notes" and a reasonable explanation made. When space on an SF-88 is inadequate, use a Continuation Sheet (SF-507).

7. Requirements for Class 2 Flight Officers.

- a. Flight Officer Candidates. Flight officer candidates shall meet the standards for Class 1 except that depth perception is not required.
- b. Designated Flight Officers. Flight officers shall meet the standards for flight officer candidate except that uncorrected distant visual acuity must be not less than 20/200 in either eye and shall be correctable to 20/20.

8. Requirements for Class 2 Aircrew.

- a. Aircrew Candidates. Unless otherwise directed by Commander CGPC-epm, personnel will not be permitted to undergo training leading to the designation of aircrewmembers unless a flight surgeon/aviation medical officer has found them physically qualified for such training. Should it be desirable, for exceptional reasons, to place in training a candidate who does not meet the prescribed physical standards, the commanding officer may submit a request for a waiver, with the SF-88 and SF-93, to Commandant (G-PRJ), justifying the request. Aircrew candidates shall meet the standards for Class 1, except that minimum height is 152.5 cm/60 inches and uncorrected distant visual acuity must be not less than 20/100 each eye, correctable to 20/20 each eye.
- b. Designated Aircrew. Aircrew shall meet the standards for Class 1, except the minimum height is 152.5 cm/60 inches.



9. Requirements for Class 2 Medical Personnel.
- a. Flight Surgeon (FS)/Aviation Medical Officer (AMO)/FS Candidates. While assigned to a Duty Involving Flight Operations billet, FS/AMOs shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).
  - b. Aviation MEDEVAC Specialists (AMS)/AMS Candidates. Health Services technicians (HS) who are assigned to flight orders. Aviation MEDEVAC Specialists shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).
10. Requirements for Class 2 Technical Observers. The term "technical observer" is applied to personnel who do not possess an aviation designation but who are detailed to duty involving flying. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. They shall meet the standards prescribed for general duty. These personnel are not required to undergo a physical examination for flying provided a complete physical examination, for any purpose, has been passed within the preceding 60 months and intervening medical history is not significant. The physical examination need not be conducted by an FS/AMO. Technical observers who are required to undergo egress training must have a current (general purpose) physical examination and a status profile chit indicating "OK DIF/Dunker/Chamber."
11. Requirements for Class 2 Air Traffic Controllers. Air traffic controllers, tower controllers, and ground control approach operators shall meet the general physical standards for Class 1, except:
- a. Articulation. Must speak clearly and distinctly without accent or impediment of speech that would interfere with radio communication. Voice must be well modulated and pitched in medium range. Stammering, poor diction, or other evidence of speech impediments, that become manifest or aggravated under excitement are disqualifying.
  - b. Height. Same as general service.
  - c. Visual Acuity.
    - (1) Candidate's visual acuity shall be no worse than 20/100 for each eye correctable to 20/20 each eye and the correction shall be worn while on duty.
    - (2) Personnel already designated shall have distant visual acuity no worse than 20/200 each eye correctable to 20/20 each eye and the correction shall be worn while on duty.
    - (3) Air traffic controllers whose vision becomes worse than 20/200 either eye may not engage in the control of air traffic in a control tower but may be otherwise employed in the duties of their rating.
  - d. Depth Perception. Normal depth perception is required.



- e. Heterophoria. The following are disqualifying:
  - (1) esophoria or exophoria greater than 6 prism diopters; and
  - (2) hyperphoria greater than 1 prism diopter.
- 12. Requirements for Landing Signal Officer (LSO).
  - a. Physical Examinations for Landing Signal Officer (LSO).
    - (1) Candidates. Officer and enlisted candidates for training as LSO's shall have a physical examination prior to the training leading to qualification. LSO duties for flight deck require stricter visual acuity standards than those for general duty in the Coast Guard. Examination by a FS/AMO is not required.
    - (2) Reexamination. Biennial reexamination is required of all currently qualified LSO's.
  - b. Physical Standards for LSO's. In addition to the physical standards required for officer and enlisted personnel, the following standards apply:
    - (1) Distant Visual Acuity. The uncorrected distant visual acuity shall be no worse than 20/200 in each eye and must be correctable to 20/20 in each eye. If the uncorrected distant visual acuity is less than 20/20 in either eye, corrective lenses must be worn while performing LSO duties.
    - (2) Depth Perception. Normal depth perception is required.
    - (3) Color Vision. Normal color perception is required.
- 13. Contact Lenses.
  - a. Class 1 personnel may be authorized by their local flight surgeon to wear contact lenses while flying, provided the following conditions are met:
    - (1) Only gas permeable disposable soft lenses may be used.
    - (2) The lenses are to be removed during the hours of sleep.
    - (3) The lenses are disposed of after 2 weeks of use.
    - (4) All prescribed optometry follow-up visits are adhered to. After routine safe use has been established and documented by the prescribing optometric authority, an annual optometric recheck is the minimum required. A copy of the record of any visit to an eye care professional will be furnished by the member to the local flight surgeon for review and placement in the member's health record.
    - (5) Following any change in the refractive power of the contact lens, the member must be checked on the AFVT to ensure that Coast Guard Class I standards for acuity and depth perception are met. In addition, the flight surgeon shall document that there is no lens displacement, when user moves his/her eyes through all 8 extreme ranges of gaze.



- (6) Contact lens case, saline for eye use, and an appropriate pair of eyeglasses are readily accessible (within reach) to the lens wearer while in-flight.
  - (7) Contact lens candidate submits request to the command agreeing to abide the above conditions.
  - (8) The flight surgeon authorizes use of contact lenses after ensuring that such use is safe and the user fully understands the conditions of use. This authorization expires after one year. Initial and any annual re-authorizations shall be documented by an entry in the health record.
  - (9) Contact lens use is not a requirement for aviation operations. The decision to apply for authorization is an individual option. Accordingly, lens procurement and routine optometric care related to contact lens use at government expense are not authorized.
- b. The optional wearing of contact lenses by Class 2 personnel performing duty involving flying and by air control personnel in the actual performance of their duties is authorized under the following circumstances:
- (1) Individuals are fully acclimated to wearing contact lenses and visual acuity is fully corrected by such lenses;
  - (2) Individuals wearing contact lenses while performing flight or air control duties have on their person, at all times, an appropriate pair of spectacles;
  - (3) A flight surgeon has specifically authorized the wearing of contact lenses while performing flight or air control duties (An entry shall be made on SF-600 in the individual's health record authorizing wearing of contact lenses.); and
  - (4) Wearing contact lenses while performing aviation duties is an individual option. Accordingly, procuring contact lenses at government expense is not authorized.



Figure 3-G-1

# Sitting Height

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## Purpose

This measurement is important in the design and layout of work stations occupied by Navy personnel. Controls must be placed in numerous locations, and the minimum acceptable space between the helmet and the canopy of cockpits must be considered.

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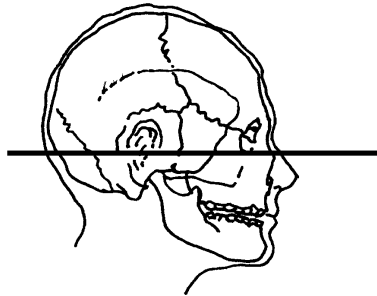
## Equipment Required

Anthropometer

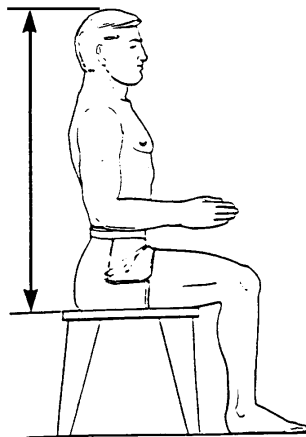
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## Measurement Procedure

1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel, and the knees are flexed 90° with the feet in line with the thighs.



2. Measure the vertical distance between the sitting surface and the top of the head with an anthropometer. The shoulders and upper extremities should be relaxed. Measure at the maximum point of quiet respiration.



**NOTE:** Measurements are to be taken to the nearest eighth of an inch. The measurement should be taken at least twice. If there is a large variation between the two measurements, recheck the body position and repeat measurements.



# Eye Height, Sitting

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## Purpose

Sitting Eye Height plays a decisive role in instrument panel layout, viewing angles, and seat adjustment, since the pilot must have optimum vision both inside and outside of the cockpit.

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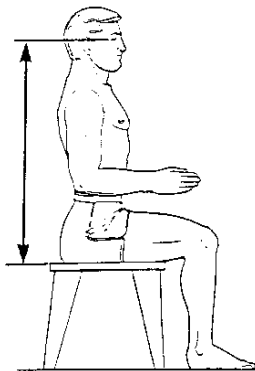
## Equipment Required

Anthropometer

---

## Measurement Procedure

1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel and the knees are flexed  $90^\circ$  with the feet in line with the thighs.



2. Measure the vertical distance between the sitting surface and the corner or angle formed by the meeting of the eyelids on the outer corner of the right eye with an anthropometer.



**NOTE:** Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.



# Thumbtip Reach

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## Purpose

This measurement is important in the design and layout of work stations occupied or used by Navy personnel. Thumbtip reach is particularly useful for the placement of controls in various locations within cockpits.

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## Equipment Required

Wall-mounted linear scale.

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## Measurement Procedure

1. The subject stands erect in a corner looking straight ahead with the feet together and heels 7.87 inches (20 cm) from the back wall.
2. With the buttocks and shoulder placed against the wall, the right arm and hand (palm down) are stretched horizontally along the scale while the thumb continues along the horizontal line of the arm with the index finger curving around to touch the pad at end of the thumb.
3. The subject's right shoulder is held against the rear wall. The horizontal distance from the back wall to the tip of the right thumb is measured.



**NOTE 1:** Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.



# Buttock-Knee Length

---

## Purpose

This measurement is usually associated with ejection seat clearance and threshold values between the knee and the glare shield (or canopy bow).

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## Equipment Required

Anthropometer

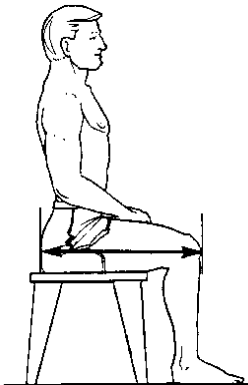
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## Measurement Procedure

1. While the subject sits erect, draw a landmark on the bottom tip of the right knee cap. The subject's thighs should be parallel, with the knees flexed at 90°. The feet should be in line with the thighs, and lying flat on the surface of a footrest or the floor.



2. The anthropometer is placed flush against the buttock plate at the most posterior point on either buttock, and the anterior point to the right knee is measured with an anthropometer.



**NOTE 1:** Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.



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## Section H Physical Examinations and Standards for Diving Duty.

### 1. Examinations.

- a. Candidates. Acceptable candidates for duty that involves diving or underwater swimming must conform to the physical standards contained in section 3-D except as modified below.
- b. Reexamination. Reexamination of all divers shall be conducted every five (5) years after designation until age 48.
- c. Examination Just Prior to Age 40. Qualified divers who desire to continue in that specialty and are about to reach age 40 must be examined by a medical officer. The SF-88 and SF-93, along with the examiner's recommendation as to whether the individual is or is not physically qualified to continue as a diver shall be forwarded to CG Personnel Command (adm-1) for final decision and in time to reach Headquarters before the individual attains age 40. A certain latitude may be allowed for a diver of long experience and a high degree of efficiency in diving. The individual must be free from any diseases of the cardiovascular, respiratory, genitourinary, and gastrointestinal systems, and of the ear. The individual's ability to equalize air pressure must be maintained.
- d. Examination Prior to Dives. Divers should ordinarily be examined prior to each unusually hazardous dive and prior to extensive operations when practicable to do so. Medical officers available during extensive operations, should make observations, by personal interview if possible, of all divers prior to their initial dive each day.

### 2. Standards.

- a. Disqualifying History. Any of the following is disqualifying:
  - (1) tuberculosis, asthma, chronic pulmonary disease;
  - (2) chronic or recurrent sinusitis, otitis media, otitis externa;
  - (3) chronic or recurrent orthopedic pathology; and
  - (4) chronic or recurrent gastrointestinal disorder.
- b. Age Requirements. Candidates beyond the age of 30 shall not be considered for initial training in diving, the most favorable age being 20 to 30. For officers undergoing training in deep sea diving for the specific purpose of becoming diving supervisors or salvage officers, the upper age limit is 39 years.
- c. Nose, Sinuses, Mouth, and Throat. Obstruction to breathing or chronic hypertrophic or atrophic rhinitis is disqualifying. Septal deviation is not disqualifying in the presence of adequate ventilation. Chronically diseased tonsils are disqualifying



pending tonsillectomy. Presence or history of chronic or recurrent sinusitis is cause for rejection.

d. Ears (General) and Drums.

- (1) Acute or chronic disease of the auditory canal, membrane tympani, middle or internal ear is disqualifying. Perforation or marked scarring or thickening of the drum is disqualifying. The eustachian tubes must be freely patent for equalization of pressure changes.
- (2) All candidates shall be subjected in a recompression chamber to a pressure of 50 pounds per square inch to determine their ability to clear their ears effectively and otherwise to withstand the effects of pressure.

e. Skin and Lymphatics. There shall be no active acute or chronic disease of the skin characterized by infectiveness and/or offensiveness in close working conditions and interchange of diving apparel.

f. Psychiatric. The special nature of diving duties requires a careful appraisal of the candidate's emotional, temperamental, and intellectual fitness. Past or recurrent symptoms of neuropsychiatric disorder or organic disease of the nervous system are disqualifying. No individual with a history of personality disorder shall be accepted. Neurotic trends, emotional immaturity or instability and antisocial traits, if of sufficient degree to militate against satisfactory adjustment are disqualifying. Stammering or other speech impediment that might become manifest under excitement is disqualifying.

g. Dental. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Advanced oral disease and generally unserviceable teeth are cause for rejection. Candidates with moderate malocclusion, or extensive restorations and replacements by bridges, may be accepted, if such do not interfere with effective use of self-contained underwater breathing apparatus (scuba). Fixed active orthodontic appliances require a waiver from CGPC-opm or epm (fixed retainers are exempt).

h. Distant Visual Acuity. Diving candidates and designated divers shall have a minimum uncorrected distant visual acuity of 20/100 in the better eye and 20/200 in the worse eye, both of which must be correctable to 20/20. Waiver considerations will be on a case-by-case basis. Emphasis on the ability to perform previous diving duties/recreational diving, if any, should be elaborated on in the applicant's letter requesting a waiver of the physical standards.



## CHAPTER 4

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## CHAPTER 4. HEALTH RECORDS AND FORMS

### Section A - Health Records.

#### 1. Purpose and Background.

- a. The health record is the chronological medical and dental record of an individual while a member of the Coast Guard or the Coast Guard Reserve. The primary reasons for compiling a health record are listed below.
  - (1) To develop an accurate clinical history that will help in future diagnosis and treatment.
  - (2) To protect the Government, the individual concerned, and the individual's dependents. It may be used in adjudicating veterans claims by making permanently available in a single record all entries relative to physical examinations, medical and dental history, preliminary to entry and throughout the individual's entire Coast Guard career. This is accomplished by opening or maintaining medical and dental records:
    - (a) upon entry into the Service;
    - (b) as required to maintain concise, yet complete, records during period of service; and
    - (c) at time of separation.
  - (3) To facilitate appraisal of the physical fitness or eligibility for benefits by making the information contained in the health record available to Coast Guard selection boards, disability evaluation system, Board of Correction of Military Records, for income tax purposes, and for claims to the Department of Veterans Affairs.
  - (4) To furnish a basis for collecting statistical information.
  - (5) To identify deceased persons through dental records when other means are inadequate.
- b. As an individual's service career progresses, the health record increases in value to the Government, the individual, and the individual's family and dependents. Accuracy, therefore, is of the utmost importance in making entries, including entries regarding minor ailments or injuries which appear trivial at the time, but which must be recorded to protect the Government and the individual.

#### 2. Contents of the Health Record.

- a. Each member's health record shall consist of CG-3443 (Health Record Cover) with medical records and dental records arranged as follows:



- (1) SECTION I - HISTORY OF CARE. Maintain the Adult Preventive and Chronic Care Flowsheet on top of this Section. All other forms in Section I are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence. Do not separate corresponding forms SF-88 and SF-93.
  - (a) Adult Preventive and Chronic Care Flowsheet Form DD 2766
  - (b) Consultation Sheet SF-513
  - (c) Narrative Summary Clinical Resume \* SF-502
  - (d) Report of Medical Examination SF-88 (Rev.10-94), and History and Report of OMSEP Examination Form CG-5447 (Rev.6-00)
  - (e) Report of Medical History SF-93 (Rev.6-96)
  - (f) Report on or Continuation of \*, \*\* SF-507
  - (g) Medical Board Report Cover Sheet \* NAVMED 6100/1
- (2) SECTION II - RECORDS OF CARE. All forms in this Section (and their civilian equivalents) are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence.
  - (a) Chronological Record of Care SF-600
  - (b) Emergency Care and Treatment SF-558
- (3) SECTION III - RADIOLOGICAL REPORTS. All forms in this Section are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence.
  - (a) Radiographic Consultation Request/Report SF-519A
  - (b) Medical Record-Radiographic Reports SF-519
- (4) SECTION IV - LABORATORY REPORTS AND ECG REPORTS. All forms in this Section are to be filed together in reverse chronological order (i.e., most recent on top) in the following bottom to top sequence.
  - (a) Clinical Record - Laboratory Reports SF-514
  - (b) Clinical Record - Electrocardiographic Record SF-520
- (5) SECTION V - MISCELLANEOUS. All forms in this Section shall be arranged in the following bottom to top sequence.
  - (a) Chronological Record of Service CG-4057



- (b) Special Duty Medical Abstract \* NAVMED 6150/2
  - (c) Record of Occupational Exposure to Ionizing Radiation \* DD-1141
  - (d) Occupational Health Surveillance Questionnaire \* CG-5197
  - (e) Syphilis Record \* SF-602
  - (f) Request for Administration of Anesthesia and for Performance of Operations and other Procedures \* SF-522
  - (g) Eyewear Prescription DD-771
  - (h) Immunization Record SF-601
- (6) SECTION VI - DENTAL RECORD AND INTERNATIONAL VACCINATION RECORD. All forms in this Section shall be arranged in the following bottom to top sequence.
- (a) International Certificate of Vaccination PHS-731
  - (b) U.S. Coast Guard Dental Record CG-3443-2
    - 1 Sensitivity Sticker \* PHS-2410
    - 2 Dental Health Questionnaire CG-5605
    - 3 Health Record - Dental -- (Continuation) \* SF-603A
    - 4 Health Record - Dental SF-603

Note:

\* --- When required

\*\* -- SF-507's are attached to and filed after the form they continue

\*\*\* - Optional Form

- b. File forms of the same number in their assigned sequence, with the most recent on top of each previous form, e.g., SF-600 dated 94/02/15 is filed on top of SF-600 dated 94/02/14.
- c. Record all dates on the Health Record Cover in the following sequence (all numerals): year/month/day (e.g., 51/02/07).
- d. Reports, including laboratory, X-ray, and consultations, shall be reviewed and initialed by the responsible MO, DO, PYA or NP before they are filed in the health record.



- e. The health record is a legal document. As such, legibility of all information is essential. Patient ID information shall be typed, printed, or stamped. All entries shall be neat and legible. All signatures shall be accompanied by the stamped or typed name and rank of the practitioner.

### 3. Opening Health Records.

#### a. General.

- (1) A health record will be opened at the recruiting office for each individual upon entry into the Coast Guard.
- (2) A new health record will be opened upon reenlistment of personnel with prior USCG service when such enlistment is not effected the day following discharge. In all cases, request the individual's health record covering prior military service from the National Personnel Records Center, St. Louis, MO.
- (3) Other Specific Occasions for Opening Health Record.

| <u>OCCASSION</u>                          | <u>OPENED BY</u>      |
|---|-----------------------|
| Officer appointed from civilian           | First duty station    |
| Reserve Officer                           | Unit where procured   |
| Cadet                                     | Academy               |
| Retired Personnel recalled to Active Duty | First duty station    |
| Original Record Lost or Destroyed         | Responsible Custodian |

### 4. Terminating Health Records.

#### a. General Instructions.

- (1) Upon discharge without immediate reenlistment or enlistment in the Coast Guard Reserve, or retirement, forward the health record (Medical Personnel Data Record or MED PDR) to the servicing PERSRU within 2 days of the member's separation. **DO NOT GIVE THE ORIGINAL HEALTH RECORD TO THE MEMBER UPON FINAL SEPARATION.** Cite the reason for separation on the reverse side of Chronological Record of Service (form CG-4057). The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC-adm3) or Commandant (G-RSM-3) for Reservists. (See Section 4-B-27 for additional requirements for CG-4057.) Health record documents are not filed in the HQ PDR. They will be returned to the unit if received by Commander, (CGPC adm-3) in error.



- (2) Discharge for immediate reenlistment at the same unit, revocation of appointment as a temporary officer to continue on active duty in permanent status, or retirement with continuation of active duty are not termination of service.
  - (3) When a health record is terminated and the dental record is not available for inclusion therein, forward a letter of explanation with the health record.
- b. Release from active duty (RELAD) with concurrent transfer to the Coast Guard Reserve or discharge from active duty with immediate enlistment in the Coast Guard Reserve. Upon RELAD, forward the health record (MED PDR) to the servicing PERSRU within 2 days of the member's separation. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to District (rs) in which the member will reside after separation.
- c. Disappearance, Other Than Desertion. Whenever an individual disappears and the facts regarding such disappearance are insufficient to justify a conclusion of death, enter a complete account of the circumstances on an SF-600 in the health record. Do not terminate the health record until final disposition.
- d. Desertion.
  - (1) When an individual is officially declared a deserter, enter an explanatory note on SF-600. Forward the health record (MED PDR) to the servicing PERSRU within 2 days of determination of deserter. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC) or Commander (CGPC-rpm) for Reservists.
  - (2) Upon return of a deserter to his/her own command, a physical examination shall be performed and recorded on an SF-88. Retain the original for incorporation into the health record, and forward a copy to Commander (CGPC) or Commander (CGPC-rpm) for Reservists with a request for the deserter's health record.
- e. Discharge of Personnel Convicted by Civilian Authorities. When the Commandant directs the discharge of personnel convicted by civilian authorities, the commanding officer will make arrangements for their physical examination, to be recorded on an SF-88. In the event no medical officer is available, obtain a statement signed by the warden of the penitentiary or reformatory that the person to be discharged from the Coast Guard is physically and mentally qualified for discharge and is not in need of hospitalization. The warden's statement, accompanied by the terminated health record, will be forwarded with the closed out service record.
- f. Discharge of Courts-Martial Prisoners Confined in Federal Penitentiaries, Reformatories, and the Naval Disciplinary Command. When the Commandant directs the discharge of a courts-martial prisoner confined in a Federal penitentiary, reformatory, or the Naval Disciplinary Command, the command to which the prisoner has been administratively assigned shall arrange with the warden for



physical examination of the prisoner. Results of this physical examination will be entered on the SF-88 and signed by the medical officer of the designated penal institution. The command to which the prisoner has been administratively assigned will terminate the health record, using the information furnished on the SF-88 and the account of medical, dental, and first aid treatments supplied by the penal institution. The terminated health record, SF-88, and the resume will then be forwarded with the closed out service record.

- g. Retired Personnel (Includes Temporary Retirement). Upon notification of retirement, make an entry on CG-4057 under "Remarks" indicating place, date, and category under which retired. The command having custody of the health record will sign the CG-4057 and forward it to the command having administrative control of the member for inclusion in the closed out service record.
  - h. Cadets. When a cadet's service is terminated, the health record will be terminated and forwarded to the Cadet Record Office, for processing. Following this procedure, the record will be forwarded to the Registrar's Office and held until the departing cadet's class graduates. When this occurs, the record will be forwarded to the Federal Personnel Records Center, St. Louis, MO. This includes cadets who graduate from the Academy but do not accept or are not tendered a commission.
  - i. Officers (Reserve) to Inactive Duty and Officers (Regular) who Resign to Accept a Reserve Commission. In the case of reserve officers being released to inactive duty and regular officers who resign and accept a commission in the reserve, the health record will be terminated.
  - j. Death. Upon notification of death, make an entry on CG-4057 under "Remarks" indicating place, time, date, and a short explanation of the circumstances surrounding death. A commissioned officer will sign the CG-4057 and then deliver it and the terminated health record to the commanding officer (no later than the day following death) for inclusion in and transmittal with the member's service record to Commander (CGPC) or Commander(CGPC-rpm).
5. Custody of Health Records.
- a. General Responsibilities.
    - (1) Health records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). Health record custody and security requirements are applicable to all documents which contain health information, whether or not filed in the health record, such as Inpatient Medical Records and mental health treatment records. Disposal of all health record documents shall be in accordance with Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).



- (a) Since health records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).
  - (b) Except as contained in the Privacy and Freedom of Information Acts Manual, the information contained in health records shall not be disclosed by any means of communication to any person, or to any agency unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.
- (2) Health records shall be retained in the custody of the Chief, Health Services Division of the unit to which the individual is attached. At units where there is no medical officer attached, the health record will become the responsibility of the executive officer in accordance with Coast Guard Regulations, COMDTINST M5000.3(series), who may delegate custody to the senior health services department representative. At units without a health services technician the custody of the health record is the responsibility of the unit's executive officer. Maintenance of these health records may be delegated to health services personnel of another unit (e.g., groups, support centers, etc.). **At no time shall individual members keep or maintain their own health record.** If there is a need to check out a health record for an appointment at another health care facility, the health record custodian shall have the member complete and sign the health record receipt form (NAVMED 6150/7). The health record custodian shall place the record in an envelope, hand it to the member, and tell the member to return the record as soon as possible following the appointment. The envelope used for record transportation shall bear a printed request reminding outside providers to treat the contents as confidential, and requesting providers to include copies of their consultations or case notes for placement in the health record. The responsibilities contained herein are also applicable to Reserve components.
- (3) Individuals may examine their own health record in the presence of a health services department representative, providing:
  - (a) such examination does not interrupt the unit's scheduled mission, and
  - (b) there is no information contained therein that would be detrimental to the individual's mental well-being, as determined by the member's attending physician.
- (4) Health records are subject to inspection at any time by the commanding officer, executive officer, duly appointed counsel in the case of formal hearings, or duly appointed Coast Guard officials who are conducting authorized investigations. Such inspections will be conducted in the presence of a health services department representative to aid in the interpretation of information contained in the health record.



- (5) Health services personnel making entries in health records shall ensure all entries, including signatures, are neat and legible. Signature information shall include the stamped or printed name and grade or rate of the signer. Facsimile signature stamps may only be used on the PHS-731 and the SF-601.
- (6) If an erroneous entry is made in a health record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.
- (7) Health services personnel are responsible for the completeness of the entries made on any medical or dental form while the health record is in their custody. No sheet shall be removed from the health record except under conditions specified in this Manual.
- (8) Members are not authorized to write in, alter, remove documents from, or otherwise change their health record or its contents. Request for changes to health record contents shall be made in accordance with procedures contained in Chapter 16 of the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3.

#### 6. Transfer of Health Records.

- a. When active duty or reserve personnel are transferred, The Chief Health Services Division, his designee, the Executive Officer, or the senior Health Services department representative will make the necessary entries in the health record and ensure that the current health record, dental record (SF-603) and Certificate of Vaccination (PHS-731), if applicable, are properly completed.
- b. A DD877 shall be initiated for each record transferred (see Figure 4-B-24). The DD877 shall be attached to the front cover of the record. The health record will be forwarded to the Coast Guard clinic or Independent Duty Health Services Technician servicing the gaining unit. **Only certified mail with return receipt will be used for records transfer.** (See Article 4-D-7.c. of this Manual for policy regarding transfer of Clinical Records of dependents.)
- c. Transfer to Federal Penitentiaries, Reformatories, or the Naval Disciplinary Command. A letter of transmittal and a copy of the health record shall accompany a member who is being transferred under sentence of a courts-martial (who has not been or will not be discharged immediately) to a penal institution for execution of the unexpired sentence. The original health record, with a letter of transmittal stating the name of the penal institution to which the prisoner is being transferred and the length of the sentence, shall be forwarded to the command to which the member has been administratively assigned which shall maintain the health record until the prisoner has been discharged from the Service. A copy of the letter of transmittal shall also be forwarded to Commander (CGPC).



7. Creating an Additional Volume.

- a. Due to chronic medical conditions, long narrative summaries, medical boards, etc., the record may fill to capacity which may cause the loss or damage to new records.
- b. Procedures for creating a second volume:
  - (1) Obtain a new Health Record (CG-3443) and transcribe the information from the original jacket.
  - (2) Write "VOLUME II" in bold print in the lower left corner of the new jacket cover. Insert forms required by this chapter.
  - (3) Write "VOLUME I" in bold print in the lower left corner of the original jacket cover.
  - (4) Transfer all documents pertaining to current or chronic illness to the new record.
  - (5) Remove the most recent SF-600 from VOLUME I and place it in VOLUME II. Insert a blank SF-600 on top of the remaining forms in VOLUME I and draw a diagonal line across the page. Enter the following on this line:

CLOSED. NO FURTHER ENTRIES IN THIS RECORD. REFER TO  
VOLUME II.

- (6) Insert the most recent Report of Medical Examination (SF 88) and the Report of Medical History (SF 93) into VOLUME II.
- (7) Transcribe the immunization and HIV test date information onto a blank SF-601 and insert it in the appropriate section of VOLUME II.
- (8) Place the original Problem Summary List (NAVMED 6150/20) into VOLUME II and a copy of this form in VOLUME I with the annotation, "CLOSED. NO FURTHER ENTRIES.", below the last entry.
- (9) Place the original Chronological Record of Service (CG 4057) in VOLUME II and a copy in VOLUME I.

8. Lost, Damaged, or Destroyed Health Records.

- a. If a health record is lost or destroyed, a complete new health record shall be opened by the unit health record custodian. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing health record should be recovered, any additional information or entries in the replacement record shall be inserted in the old record.



- b. Health records which become illegible, thus destroying their value as permanent records, shall be restored and duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Take particular care in transcribing the date on SF-88 into the new record as such information may be required by the Department of Veterans Affairs to determine the individual's right to pension or other Federal benefits. Stamp or mark "DUPLICATE" on the cover of the new record. Explain the circumstances necessitating the duplication on an SF-600. Forward health records replaced by duplicate records to CGPC-adm-3.

9. Accuracy and Completeness Check.

- a. Upon transfer of an individual, the health record custodian at both the detaching unit and the receiving unit shall inspect the health record for accuracy and completeness, in accordance with the following guidelines:
  - (1) that all immunizations are up-to-date (See Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series));
  - (2) that PPD screening is current in accordance with Section 7-D of this Manual;
  - (3) that all required audiograms are completed, especially on personnel involved in the hearing conservation program;
  - (4) that required forms have been properly completed and are in the correct order;
  - (5) that all deficiencies in physical requirements shall be scheduled for correction, all missing forms shall be replaced, and all other clerical or administrative errors corrected; and
  - (6) that all OMSEP requirements are met.
- b. The health record custodian shall ensure that all identified deficiencies are corrected immediately. Appointments shall be scheduled and the individual's supervisor notified of the need to correct deficiencies as soon as possible.
- c. Upon separation of the individual from the Service, the unit terminating the health record will inspect the health record, correct all errors, fill in omissions, and make sure the patient identification information is completed on all forms.



Section B - Health Record Forms.

1. CG-3443 (Health Record cover). (See FIGURE 4-B-1) Each patient's health record shall be maintained in a CG-3443 (Health Record Cover). The CG-3443 shall be completed according to the following instructions:
  - a. Last Name. Record in all capital letters.
  - b. Given Name(s). Record given name(s) in full without abbreviations. If the individual has no middle name or initial then use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s) record each initial in quotation marks. When "Jr." or "II" or other similar designations are used they shall appear after the middle name or initial.

**DOE      John      Buck      Jr.**

**Surname   First Name   Middle Name**

- c. Beneficiary. Enter the appropriate beneficiary code to describe the patient (enter "20" for active duty members).
  - (1) 01 to 19 - Dependent children in order of birth
  - (2) 20 - Sponsor
  - (3) 30 - Spouse
  - (4) 31-39 - Unremarried former spouse
  - (5) 40 - Dependent mother (active duty)
  - (6) 45 - Dependent father (active duty)
  - (7) 50 - Dependent mother-in-law (active duty)
  - (8) 55 - Dependent father-in-law (active duty)
  - (9) 60 - Other dependents
  - (10) 80 - Humanitarian (non-eligible)
  - (11) 90 - Civilian employee
  - (12) 99 - Other eligible
- d. Sponsor's Social Security Number. Enter.
- e. Blood Type and Rh Factor. Enter the blood-type and Rh factor in the appropriate boxes. Use utmost caution when recording this information. If not known, complete a blood-type and Rh factor test as required.



- f. Special Status. Check the appropriate block to indicate whether the individual is in aviation or diving status, has a waiver, requires occupational monitoring, or has an allergy.
  - g. Date of Birth. Enter year, month and day (e.g., 51/02/07).
  - h. Local Use. Use the spaces provided below the sensitivity sticker location for local use information such as rank, unit, etc. as needed.
2. CG-5266 (Drug Sensitivity Sticker).
- a. General. Form CG-5266 should be initiated for anyone having documented history of sensitivity or hypersensitivity to specific drugs, serums, or vaccines, including PPD converters. Other non-drug allergies should be indicated on this form only if they will affect potential therapy (e.g., egg yolks). Every effort shall be made to verify the reported sensitivity and to confirm that it is allergic in nature.
  - b. Detailed Instructions.
    - (1) Prepare two originals. (One each for the health and dental records.)
    - (2) List the name of each drug, serum, vaccine, or anesthetic indicated on the Problem Summary List (NAVMED 6150/20).
    - (3) Affix the CG-5266 vertically to the indicated location on the health record cover (form CG-3443) and vertically to the lower left corner on the front of the dental record cover (CG-3443-2).
3. DD2766 (Adult Preventive and Chronic Care Flowsheet Form). (Figure 4-B-2)
- a. General. The Adult Preventive and Chronic Care Flowsheet Form documents significant/chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, PPD, DNA & HIV testing, screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exam, etc), and chart audits. In-house training sessions should be conducted prior to the implementation of this form
  - b. Detailed Instructions. DD2276 should be inserted as the first page of the medical record and all sections completed by the health care provider with the following guidelines exceptions:
    - (1) Information from previous Problem Summary Lists should be copied and updated onto the DD2276 as it is placed in the health record.
    - (2) Sections 8.a., 10.e. and 10.i. are not required to be completed.
    - (3) Use a pencil to darken the circles on Section 7, Screening Exam.



- (4) The medical officer should enter the date and location of every deployment the member participates in Section 11, Pre/Post Deployment History. Pre and post deployment questionnaires are documented in Section 11 for participants in DOD deployment.

4. SF-600 (Chronological Record of Medical Care).

a. General.

- (1) This form provides a current, concise, and comprehensive record of a member's medical history. Properly maintained, the SF-600 should: aid in evaluating a patient's physical condition; greatly reduce correspondence to obtain medical records; eliminate unnecessary repetition of expensive diagnostic procedures; and serve as an invaluable permanent record of health care received. The SF-600 shall be continuous and include the following information as indicated: complaints; duration of illness or injury, physical findings, clinical course, results of special examinations; treatment; physical fitness at time of disposition; and disposition. The SF-600 also serves as the patient's prescription from which pharmacy services are provided.
- (2) When a new SF-600 is initiated, complete the identification block with the name (last, first, middle initial), sex (M or F), year of birth, component (active duty or reserve), service (USCG, USN, USA, etc.), Social Security Number, and the member's grade/rate and organization at the time the form is completed.
- (3) File SF-600's on the right side of the medical record with the most current SF-600 on top.
- (4) Enter sick call entries on SF-600 in the following SOAP format (See FIGURE 4-B-3).

**SOAP METHOD OF SICK CALL WRITE UPS**

**S: (Subjective).**

cc: (Chief Complaint) sore throat, cough, diarrhea, etc.

hpi: (History Present Illness) onset of symptoms, all problems, review of symptoms

pmh: (Past Medical History) any related problems in past that may be present with chief complaint

fh: (Family History) any diseases, chronic/acute, possibly related to present complaint

all: (Allergies) any known allergies to drugs/medications, etc.



**0: (Objective).**

First visual assessment/evaluation of the patient's general appearance: limping, bleeding, doubled over, etc.

PE: All results of physical exam, vital signs, lab, x-ray, and any other study results

**A: (Assessment).**

Imp: (Impression, Diagnosis) includes R/O (rule out)

**NOTE: THIS IS TO INCLUDE, AFTER IMPRESSION, WHAT YOU ARE GOING TO DO NOW AND WHY--SUCH AS, SUTURING, TOURNIQUET, ETC.**

**P: (Plan).**

List of medications given, lab, x-ray, special studies ordered, duty status, return appointments, referrals, etc.

- (5) The entries for all treatments shall be complete with regard to place, date, problem number (if appropriate), number of sick days, diagnosis of all conditions for which treated and signature of individual furnishing treatment. Note all facts concerning the origin of the disease, pregnancy status, symptoms, course, treatment, and if a conflicting opinion is expressed subsequently by the same, or another medical officer, fully state the reason for such change. The record need not be voluminous, but it shall be thorough, concise, clearly phrased, and complete in each case. All entries, including signatures, must be legible.
- (6) When a member is injured or contracts a disease while on leave, or when for any other reason the facts concerning an injury or sickness have not been entered in the individual's health record, the record custodian shall ascertain the facts in the case and make the necessary entries on SF-600. Discuss and document the instructions given to the patient. Include the intended treatment and, as appropriate, possible alternative treatments, possible complications, and long term prognosis. Information regarding previous treatments should be entered giving the following: date, place, and full details of treatment; laboratory reports; x-ray results; etc. The following shall also be entered:
  - (7) "Date:  
**"Transcribed From Official Records.**  

|                       |                                     |
|-----------------------|-------------------------------------|
| <b>Signature/Rate</b> | <b>Duty Station of Transcriber"</b> |
|-----------------------|-------------------------------------|
  - (8) When an individual is required to carry the PHS-731, enter a statement of acknowledgment on the SF-600.



- (9) When an individual is diagnosed as having a Sexually Transmitted Disease (STD) make an entry to record that an interview was conducted and that the following was discussed with the patient:
  - (a) symptoms,
  - (b) complications,
  - (c) treatments, and contacts.
- 5. Treatment at Other Than Unit Assigned. When an activity furnishes sick call treatment to an individual whose health record is not available, an entry shall be made on a new SF-600 and forwarded to the individual's duty station for inclusion in the health record.
- 6. SF-88 (Report of Medical Examination).
  - a. Purpose. SF-88 is used to record and use information obtained from physical examinations.
  - b. Preparation. (See FIGURE 4-B-4)
    - (1) When Prepared. SF-88 (Rev. 10-94) shall be prepared and submitted to the reviewing authority whenever a complete physical examination is required.
    - (2) Required Entries. Certain groups of personnel are required to meet physical standards somewhat different from other groups. Accordingly, the use of all the spaces or use of the same spaces on the SF-88 is not necessarily required for reporting the results of the various categories of physical examinations. If a certain item of the medical examination is required and facilities for accomplishing it are not available, an entry "NFA" (No Facilities Available) shall be made in the appropriate space. An entry "NE" (Not Evaluated) shall be made in the appropriate space for any item of the clinical evaluation (Items 18-43) which was not evaluated. For other items listed on the SF-88 which were not required for a particular category of physical examination, an entry "NI" (Not Indicated) shall be made in the appropriate space. Reference should be made to other provisions of Chapter 3 which prescribe the nature and scope of each physical examination and indicate the applicability of items of the SF-88 to the particular program. Unless otherwise indicated by such provisions, the minimum requirements for completing an SF-88 are:
      - (a) All Examinations. Items 1-30, 33, 38, 40 and 41-51 shall be completed for all physical examinations, if facilities are available. Item 19 (cc), shall be completed for all female personnel.
      - (b) Aviation Personnel. Additionally, Items 31,32, and 34-38 shall be completed for physical examinations of aviation personnel.



- (3) A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the final recommendation. Before signing and forwarding, the examiner shall review the completed SF-88 for completeness and accuracy. Failure to do so reflects seriously on the examiner's thoroughness. Remember that the reviewing authority does not have the advantage of a direct examination and must rely on the examiner's written record and appropriate additional information in arriving at a decision.

c. Details for Entries on SF-88.

- (1) Item 1: Last Name - First Name - Middle Name. Record the surname in all capital letters. Record the given name(s) in full without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial in quotation marks (i.e., MANUEL, Thomas "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., TARVIN, Laurie (n)]. Designations, such as, "Jr." or "II" shall appear after the middle name or initial. In the absence of a middle name or initial, these designations shall appear after the "(n)."
- (2) Item 2: Identification No. Enter SSN.
- (3) Item 3: Grade and Component or Position. Use official abbreviation of the current grade or rate, branch of Service, class and status; i.e., regular, reserve, or retired and if active or inactive. Example: HSCS, USCG; LTJG, USCGR; SN, USCG (TEMPRET); ETCM, USCG (RET). If not Service member, enter "civilian."
- (4) Item 4: Home Address. Enter the evaluatee's present residence and not the home of record.
- (5) Item 5. Emergency contact, name and address.
- (6) Item 6: Date of Birth. e.g., 4 SEP 49. Enter age in parentheses above date
- (7) Item 7. Age
- (8) Item 8. Sex, check appropriate box.
- (9) Item 9. Relationship of contact. Refers to Item 5.  
Wife/husband/brother/sister/friend.
- (10) Item 10. Place of Birth. Enter city, town, or village and the state. For foreign born, enter the name of the country as known at the time of the individual's birth.
- (11) Item 11. Race. Check appropriate box.



- (12) Item 12a. Agency. Enter the OPFAC number of the unit to which the examinee is attached.
- (13) Item 12b. Organization Unit. List name of ship or station to which the examinee is assigned. If applicant for entry into Service, enter the recruiting office concerned.
- (14) Item 13. Total Years of Government Service. Enter years and months (e.g., 06 yrs 04 mos).
- (15) Item 14. Examining Facility or Examiner. For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.
- (16) Item 15. Rating or Specialty of Examiner. (i.e. Family Practitioner, Nurse Practitioner, or Flight Surgeon.
- (17) Item 16: Purpose of Examination. Enter the specific purpose(s) of the examination, such as: Original Enlistment; Applicant Coast Guard Academy; Enlistment; Prior Service; Diving Applicant; BASIC OMSEP; IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms "flight physical," "diving physical," or "aviation physical." Avoid using nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program. When necessary, continue under Item 42, Notes.
- (18) Items 17: Clinical Evaluation. Check each item in appropriate column. In the area reserved for notes, describe every abnormality in detail. Enter pertinent item number before each comment. Continue in Item 42 and use Continuation Sheets (SF-507), if necessary.
- (19) Item 18. Complete dental chart with the symbols shown. Under "Remarks" enter type of dental examination performed and the dental classification assigned. Indicate whether or not the examinee meets the dental standards for which the examination is being done. Record all dental defects and diseases discovered. Enter disqualifying dental defects in detail. When oral disease or dental defects are discovered on examination of active duty personnel, the dental examiner shall make suitable recommendations for instituting corrective measures. If a dental officer is not available, the medical officer shall determine the examinee's dental qualification. Enter the statement "Examination not performed by a dental officer" under remarks of Item 44.
- (20) Item 19 A-F: Laboratory Findings. Enter all laboratory results in quantitative values.
  - (a) Item A: Urinalysis. Enter specific gravity and results of albumin, sugar, and if required, microscopic tests in the indicated spaces.



- (b) Item B: Chest X-ray. Enter place where x-ray was taken, film number, date, and interpretation.
  - (c) Item C: Serology. Enter date, test used, and results.
  - (d) Item D: EKG. When required, enter interpretation.
  - (e) Item E: Blood Type and Rh Factor. Record blood group and Rh factor. Required on initial entry physical examinations only!
  - (f) Item F: Other Tests. Enter results of complete blood counts. Enter all other tests done and their results which are not indicated on the form and which were performed in connection with the physical examination (e.g., sickle cell test, PAP test, PPD, etc.). The results will be continued in Item 42 or on Continuation Sheets (SF-507), if necessary. If provided on the lab report, include "normal" range values for all tests performed by a civilian or military lab. Use quantitative values and not "WNL" or other such qualitative forms.
- (21) Item 20: Height. Measure without shoes and record to the nearest one-half centimeter (one-half inch).
- (22) Item 21: Weight. Measure with the evaluatee in under garments and record results to the nearest kilogram (pound).
- (23) Item 22: Hair Color. Enter the hair color as: flaxen, sand (yellow-red), auburn (red-brown), brown (light, medium or dark must be specified), black, gray, etc. Note if the hair is curly, very thin, or if the person is bald.
- (24) Item 23: Color Eyes. Enter appropriate color.
- (25) Item 24: Build. Indicate by "X" in appropriate block.
- (26) Item 25: Temperature. Leave blank.
- (27) Item 57: Blood Pressure. Record the actual value in numerals for both systolic and diastolic.
- (28) Item 26: Pulse. Record the actual pulse rate.
- (29) Item 28: Distant Vision. Test and record using the Snellen scale. Record vision in the form of a fraction and in round numbers, that is 20/20, 20/40, not 20/20-2 or 20/40-3.
- (30) Item 29: Refraction. Enter the lens prescription when the evaluatee wears (or requires) lenses for correction of visual acuity. Do not enter the term "lenses."
- (31) Item 30: Near Vision. Test and record using the Snellen scale.



- (32) Item 31: Heterophoria. Enter when indicated.
- (33) Item 32: Accommodation. Enter when indicated.
- (34) Item 33: Color Vision. Enter the test used and the results.
  - (a) Farnsworth Lantern. Record the results as "Passed FALANT" or "Failed FALANT" followed by the fraction of correct over total (i.e., 9/9 or 17/18).
  - (b) Pseudoisochromatic Plates (PIP). Record results as "Passed PIP" or "Failed PIP" followed by the fraction of correct over total (i.e., 12/14 or 14/14).
  - (c) Enter "Passed on record" or "failed on record" if the results of a previous PIP or FALANT examination are available on record for review.
- (35) Item 34: Depth Perception. When indicated, enter test used in left portion of Item 65.
  - (a) AFVT. In the appropriate space in the right-hand portion of Item 34, record the letter designation of the highest group passed (i.e., Passed F).
  - (b) Verhoeff. In the appropriate space in right-hand portion of Item 34, record perfect score as 16/16.
- (36) Item 35: Field of Vision. Enter when indicated.
- (37) Item 36: Night Vision. Enter when indicated.
- (38) Item 37: Red Lens Test. Enter when indicated.
- (39) Item 38: Intraocular Tension. When indicated, enter the results in millimeters of mercury.
- (40) Item 39: Hearing. Leave blank. Use of the Whispered Voice Test is not authorized.
- (41) Item 40: Audiometer. Required on ALL physical examinations. Use ANSI 1969 standards, do not use ISO or ASA standards.
- (42) Item 41: Psychological and Psychomotor. Enter when indicated (e.g. AA, RAT, etc.).
- (43) Item 42: Notes and Significant or Interval History. Use this space for recording items such as:
  - (a) any pertinent medical history;



- (b) summary of any condition which is likely to recur or cause more than minimal loss of duty time;
  - (c) wrist measurements;
  - (d) most recent HIV antibody test date (see Article 3-C-20.b.(5) of this Manual);
  - (e) date of PPD and results; and
  - (f) Preventive Medicine stamp per Use of Preventive Medicine Stamp, COMDTINST 6200.11(series), for exams originating in Coast Guard sickbays and clinics.
- (44) Item 43: Summary of Defects and Diagnoses. List ALL defects in order to protect the Government in the event of future disability compensation claims. All defects listed which are not considered disqualifying shall be so indicated by the abbreviation NCD (Not Considered Disqualifying). When an individual has a disease or other physical condition that, although not disqualifying, requires medical or dental treatment clearly state the nature of the condition and the need for treatment. If a medical or dental condition is disqualifying, and treatment is scheduled to be completed prior to transfer to overseas or sea duty, indicate the date the member is expected to be fully qualified, e.g., "Dental appointment(s) scheduled, patient will be class I (dentally qualified) by (date)".
- (45) Item 44: Recommendations. Indicate any medical or dental recommendations. Specify the particular type of further medical or dental specialist examination indicated (continue in Item 44 or use SF-507, if necessary).
- (46) Item 45A: Physical Profile. Leave blank.
- (47) Item 46: Examinee's Qualification. State whether or not the examinee is qualified for the purpose of the examination. If the purpose for the examination is an IMB or DMB, state whether or not the examinee is qualified or not qualified for retention and to perform the duties of his/her rank/rate at sea and foreign shores.
- (48) Item 47: Disqualifying Defects. Indicate item number only.
- (49) Items 47-51: Names and Signatures of Examiners. The name, grade, branch of Service, and status of each medical and dental examiner shall be typewritten, printed, or stamped in the left section. Each examiner shall sign using ballpoint pen or ink pen (black or blue-black ink only) in the appropriate section. Do not use facsimile signature stamps. When attachment sheets are used as a supplement or continuation to the report, they shall be serially



numbered (both sides); however, indicate only the actual number of attached sheets in the bottom right block on SF-88.

7. SF-93 (Rev. 6-96) (Report of Medical History). (See FIGURE 4-B-5)

- a. Purpose. SF-93 provides a standardized report of the examinee's medical history to help the examiner evaluate the individual's total physical condition, and to establish the presence of potentially disabling conditions which are not immediately apparent upon physical examination. In preparing the form, encourage the examinee to enter all medical problems or conditions experienced, no matter how minor they may be. The examiner must investigate and evaluate all positive medical history indicated on the form.
- b. Preparation and Submission of SF-93. Prepare and submit SF-93 with all physical examinations except: Periodic OMSEP and Substitution/Overseas/Sea Duty Modified Physical Examination.
- c. Preparation Procedures. SF-93 shall be prepared by the examinee and the examining medical officer.
  - (1) The examinee shall furnish a true account of all injuries, illnesses, operations, and treatments since birth. False statements or willful omissions in completing the SF-93 may result in separation from the Service upon arrival at the Academy, Recruit Training Center, Officer Candidate School, or later in the individual's career.
  - (2) A copy of the SF-93 must be included in the member's health record. Entries must be printed, in the examinee's and examiner's own handwriting, using either ball-point pen or ink pen (black or dark blue). Pencils or felt-tip pens will not be used. Information in the numbered blocks on the form will be entered in the following manner:
    - (a) Block 1: Enter name as follows: SMITH, Hannibell H. Record the surname in all capital letters. Record the given name(s) in full, without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial within quotation marks. If the individual has no middle name, enter the letter "(n)" in parenthesis. Designations such as "Jr." or "II" will appear after the middle name or initial or after "(n)" if there is no middle name.
    - (b) Block 2: Enter SSN.
    - (c) Block 3. Use official abbreviation of current grade or rate, branch of the Service, class and status; i.e., regular, reserve, or retired and if active or inactive. Example: HSCM, USCG; LTJG, USCGR; HSC, USCG (RET); HS3, USCG (TEMPRET). If not a Service member, enter "civilian."



- (d) Block 4a-d: Home Address - Enter the evaluatee's present residence and not the home of record.
- (e) Block 5: Examining Facility or Examiner - For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.
- (f) Block 6: Purpose of Examination - Enter the specific purpose(s) of the examination, such as: Original Enlistment; Applicant, Coast Guard Academy; Separation; Enlistment, Prior Service; Diving Applicant; BASIC OMMP; etc. Do not use the incomplete terms "flight physical," "diving physical." Avoid using nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program.
- (g) Block 7a: The examinee shall enter a statement as to present health and a list of medications presently being taken. For individuals receiving examinations more frequently than quinquennial, there is often little change in the medical history from year to year. As an alternative to having the examinee complete Section 10 of the SF 93 at a periodic examination, the following statement may be entered in block 7a and initialed by the person undergoing the examination.

"I have reviewed my previous Report of Medical History and there have been no changes since my last medical examination, except as noted below." \_\_\_\_\_(initials)

- (h) Blocks 10-22: Self-explanatory.
- (i) Block 23. List all immunizations received.
- (j) Block 25: Prior to performing the physical examination, the examiner will review the completeness of the information furnished on the SF-93. When this is done, summarize the medical history under Block 25 as outlined below and then sign the form. If additional space is needed, use Continuation Sheet, SF-507.
- (k) Do not use the term "usual childhood illnesses"; however, childhood illnesses (those occurring before age 12) may be grouped together enumerating each one. Incidents, other than those occurring in childhood, shall have the date recorded rather than the examinee's age. Do not use "NS" or "non-symptomatic" for items of history. Use "NCNS," "No Comp., No Seq." after items of recorded history where applicable. Elaborate on all items of history answered affirmatively except "Do you have vision in both eyes". The following specific questions shall also be asked on examination for initial entry into the Coast Guard, and for aviation and diving duty applicants:



- 1 "Is there a history of diabetes in your family (parent, sibling, or more than one grandparent)?"
- 2 "Is there a history of psychosis in your family (parent or sibling)?"
- 3 "Do you now or have you ever worn contact lenses?"
- 4 "Do you now or have you ever used or experimented with any drug, other than as prescribed by a physician (to include LSD, marijuana, hashish, narcotics, or other dangerous drugs as determined by the Attorney General of the United States)?"
- 5 "Have you ever required the use of an orthodontic appliance attached to your teeth or a retainer appliance? Month and year last worn? Are they still necessary?"
- 6 "Are there any other items of medical or surgical history that you have not mentioned?" All affirmative answers to the above questions shall be fully elaborated in Item 25. Negative replies to the above questions shall be summarized as follows: "Examinee denies history of psychosis, use of drugs, history of wearing of contact lenses, requirement for any orthodontic appliance, all other significant medical or surgical history; family history of diabetes." A rubber stamp or the overprinting of this information in Item 25 is recommended.

(3) Distribution. Attach the original SF-93 to the original SF-88 and submit to reviewing authority. A copy of the SF-93 and SF-88 shall be kept on file at the unit pending the return of the approved SF-93 and SF-88. After review and endorsement, the reviewing authority shall forward the original SF-93 and SF-88 to the members parent command for insertion into the members health record.

9. SF-558 (Emergency Care and Treatment) (Rev 9-96). (See Figure 4-B-6) This form provides a comprehensive yet concise record of emergency health care. It shall be used whenever an individual receives emergency treatment. Detailed instructions for completing the form are as follows:
  - a. Patient's Home Address or Duty Station. Complete all blocks in this section.
  - b. Arrival. Record the date and time the patient arrived at the clinic or emergency room for care.
  - c. Transportation to Facility. Record the name of the ambulance company or unit that transported the patient for care, if appropriate. If patient was not transported by ambulance or other emergency vehicle, enter "N/A".



- d. Third Party Insurance. List detailed insurance if known by patient. If potential third party liability exists, forward a copy of SF-558 to Commandant (G-WRP-2). Note: Disregard DD2568 in chart, enter N/A).
- e. Current Medications. List all medications patient is presently taking.
- f. Allergies. Record any substance or drug to which the patient has a known or suspected allergy. If none, enter "NKA" (No Known Allergy).
- g. Injury or Occupational Illness. Most fields. When, refers to date injury was sustained. Where, refers to location injury occurred. How, refers to what happened (briefly).
- h. Emergency Room Visit. Self-Explanatory.
- i. Date of Last Tetanus Shot. Self-Explanatory.
- j. Chief Complaint. Record a brief description of why the patient is seeking health care.
- k. Category of Treatment. If Condition is Result of Accident/Injury. Check the block that best describes the patients' condition upon arrival.
  - (1) Emergent. A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.
  - (2) Urgent. A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.
  - (3) Non-Urgent. A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute
- l. Vital Signs. Take and record all vital signs. Indicate the time vitals were taken. Use 24-hour clock annotation i.e. 0215.
- m. Lab Orders and X-Ray Orders. Self-Explanatory, check appropriate box.
- n. Orders. List orders given by provider. Record all medications, appointments made. Or any other follow-up plans.
- o. Disposition. Check appropriate box. Ensure patient understands this section.
- p. Patient/Discharge Instructions. Be specific. Ensure patient understands instructions given.
- q. Patients Signature and Date. Have the patient or person accompanying the patient sign the form. This signature only acknowledges that instructions were given to the patient.



- r. Time Seen by Provider. Record the time when the patient received treatment. Use 24-hour clock annotation i.e. 0215.
  - s. Test Results. Record results of tests ordered on patient.
  - t. Provider History/Physical. Self-explanatory, use standard S.O.A.P. format.
  - u. Consult With. List all individuals that on-scene provider received medical advice from. Example Dr. Richard Smith.
  - v. Diagnosis. Record patient diagnosis.
  - w. Providers Signature and Date. The medical officer or other health care provider shall sign and date the form.
  - x. Codes. List all ICD-9 codes applicable to the patient.
  - y. Patients' Identification. Ensure all patient identification information is entered.
10. DD-2215 Reference Audiogram. Suspend from future use. Do not remove existing forms from health record (file under section IV).
11. DD-2216 Hearing Conservation Data. Suspend from future use. Do not remove existing forms from health record (file under section IV).
12. SF-502 (Narrative Summary). (See FIGURE 4-B-7) SF-502's are used for a variety of purposes, such as:
- a. to summarize the important facts about a patient's hospitalization;
  - b. to summarize the findings of a medical board; or
  - c. to report the results of a Board of Flight Surgeons.
- If received subsequent to the individual's discharge from the hospital, it shall be inserted in the health record immediately upon receipt.
13. NAVMED 6100/1 (Medical Board Report Cover Sheet).
- a. The NAVMED 6100/1 is used in preparing a medical board. A copy of the NAVMED 6100/1 and the complete medical board shall be inserted into the individual's health record.
  - b. Detailed instructions for preparing and distributing this form are contained in Physical Disability Evaluation System, COMDTINST M1850.2 (series).
14. SF-513 (Consultation Sheet). (See FIGURE 4-B-8)



14. SF-513 (Consultation Sheet). (See FIGURE 4-B-8)

- a. Purpose. SF-513 is used whenever a patient is referred to another facility for evaluation.
- b. Detailed Instructions. Complete the form as follows:
  - (1) To. Facility or department to which the patient is being referred.
  - (2) From. Unit referring the patient.
  - (3) Date of Request. Self-explanatory.
  - (4) Reason for Request. Specify the reason for referring the patient, i.e., chest pains, infected sebaceous cyst, etc.
  - (5) Provisional Diagnosis. Self-explanatory.
  - (6) Doctor's Signature. Must be signed by a medical officer, dental officer, or health services department representative. Accompanying this signature should be the qualifying degree of the individual requesting the consult.
  - (7) Approved. Leave Blank.
  - (8) Place of Consultation. Check the appropriate block.
  - (9) Emergency/Routine. Check the appropriate block.
  - (10) Identification No. Enter the patient's SSN.
  - (11) Organization. Enter patient's branch of service.
  - (12) Register No. If inpatient, enter the appropriate register number. If outpatient, leave blank.
  - (13) Ward No. If outpatient enter "OP." If inpatient, enter appropriate ward number.
  - (14) Patient's Identification. Enter the appropriate patient identification information.
  - (15) The remainder of the form is completed by the consultant.
- c. When the consultation sheet (SF-513) is completed and returned by the consultant, the following actions are required:
  - (1) Originator shall review and sign the SF-513;



- (2) Originator shall complete a Visit Profile sheet (CG-5460B) as directed by Use of Clinic Automated Management System (CLAMS), COMDTINST 6010.18(series) for later entry into CLAMS; and
- (3) The SF-513 shall then be filed in the appropriate dental or medical section of the health record.

15. SF-520 (Electrocardiographic Report). (See FIGURE 4-B-9)

- a. Purpose. SF-520 is used to report the results of all electrocardiograms.
- b. Detailed Instructions. The individual performing the electrocardiogram shall complete the form as follows:
  - (1) Previous ECG. Check appropriate block
  - (2) Clinical Impression. Reason why the electrocardiogram was requested, e.g., chest pain, physical examination, etc.
  - (3) Medication. Enter any medications that the patient is taking.
  - (4) Emergency/Routine. Check appropriate block.
  - (5) Bedside/Ambulant. Check appropriate block.
  - (6) Age. Enter patient's age as of last birthday.
  - (7) Sex. Enter "M" or "F," as appropriate.
  - (8) Race. Leave blank.
  - (9) Height. Enter to nearest one-half centimeter (one-half inch).
  - (10) Weight. Enter to the nearest kilogram (pound).
  - (11) B.P. Enter recumbent blood pressure.
  - (12) Signature of Ward Physician. Signature of medical officer ordering the electrocardiogram.
  - (13) Date. Date the ECG was performed using appropriate format.
  - (14) Register No. Enter patient's social security number.
  - (15) Ward No. Enter "OP" (outpatient) or appropriate ward no.
  - (16) Patient's Identification. Enter the appropriate patient identification information.



- (17) The remainder of the form is completed by the medical officer evaluating the electrocardiogram.
- c. The baseline ECG shall be appropriately marked "Baseline ECG."
16. SF-515 (Tissue Examination). (See FIGURE 4-B-10)
- a. Prepare a SF-515 whenever a tissue specimen is forwarded to a laboratory for examination.
- b. Ensure patient's identification information is completed.
17. SF-541 (Gynecologic Cytology). (See FIGURE 4-B-11)
- a. Prepare a SF-541 whenever a vaginal or cervical smear (PAP test) is forwarded to a laboratory for examination.
- b. Ensure patient's identification information is completed.
18. SF-514 (Laboratory Reports). (See FIGURE 4-B-12)
- a. This is a display form for mounting graphic reports, automated printout reports, or printed reports associated with special equipment.
- b. Attach the laboratory reports to the indicated spaces with the most recent on top.
- c. Ensure patient's identification information is completed.
- d. Clinical Record - Laboratory Report Display (SF-545). May be used in lieu of SF-514. This is a display form for mounting laboratory requests and report forms. When a patient will require the same type of test several times, a separate display sheet shall be used for each type of test. In low use situations, the various test result forms should be mounted on alternate strips 1, 3, 5, and 7.
- (1) The following Standard Forms should be mounted serially on strips 1, 2, 3, 4, 5, 6, and 7:
- (a) Chemistry I (SF-546),
- (b) Hematology (SF-549),
- (c) Urinalysis (SF-550), and
- (d) Serology (SF-551).
- (2) The following Standard Forms be mounted on alternate strips 1, 3, 5, and 7:
- (a) Chemistry II (SF-547);
- (b) Chemistry II (Urine) (SF-548);



- (c) Parasitology (SF-552);
  - (d) Spinal Fluid (SF-555); and
  - (e) Immunohematology (SF-556).
- e. In many instances there will be a mixed assortment of Standard Forms to be mounted in a patient's chart and obviously these should be mounted in the most practical sequence.
- f. Instructions for attaching the laboratory report forms to this display sheet are printed at the bottom of the SF-545. A check mark in the space in the lower right corner identifies the name of the laboratory forms that are displayed on this sheet or indicates that a variety or assortment of forms is displayed on the sheet.
19. SF-545a - Clinical Record - Laboratory Report Display for SF-553, SF-554, and SF-557. This is a display form for mounting Microbiology I, Microbiology II, and miscellaneous forms for inclusion in the health record. It may be used, when indicated, in addition to SF-514.
20. SF-546 - 557 (Laboratory Requests).
- a. SF-546 (Chemistry I). Used to request most blood chemistry tests. Fill in the identification data as described previously. The specimen sources information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER. The names of the blood chemistry tests are listed individually on this form. At the bottom of the list there is provision for ordering a battery or profile of tests. When requesting the identifying names of the battery or profile of tests must be written into the space provided. There is also space for writing in the names of other tests not specifically listed.
  - b. SF-547 (Chemistry II). Used to request blood gas measurement, T3, T4, serum, iron binding capacity, glucose tolerance, and other chemistry tests. Fill in the identification data as described previously. The specimen source information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER.
  - c. SF-548 (Chemistry II, Urine). Used to request chemistry tests on urine specimens. The specimen interval information is given by checking the box marked 24 HOURS or by specifying information in the position marked OTHER.
  - d. SF-549 (Hematology). Used to request routine hematology tests. The specimen source information is given by checking box marked VEIN, the box marked CAP for capillary, or by specifying information in the position marked OTHER.
  - e. SF-550 (Urinalysis). Used to request urinalysis tests, including routine urinalysis with microscopic examination. The specimen source information is given by checking the box marked ROUTINE or by specifying information in the position



marked OTHER. (Note that routine urinalysis may be ordered by simply placing an "X" in front of the word MICROSCOPIC in the requesting section.) The space marked PSP is for requesting and reporting phenolsulfonphthalein measurements. The space marked HCG is for requesting and reporting measurements of human chorionic gonadotropin.

- f. SF-551 (Serology). Used to request tests that measure serum antibodies, including tests for syphilis.
- (1) The space marked RPR is for requesting and reporting measurements of the Rapid Reagent Card Test for Syphilis
  - (2) The space marked TA is for requesting and reporting measurements of the Latex Fixation Test for Thyroglobulin Antibodies.
  - (3) The space marked COLD AGG is for requesting and reporting of Cold Agglutinins.
  - (4) The space marked ASO is for requesting and reporting Antistreptolysin O titers.
  - (5) The space marked CRP is for requesting and reporting measurements of C Reactive Protein.
  - (6) The space marked FTA-ABS is for requesting and reporting for fluorescent treponemal antibody-absorption test.
  - (7) The space marked FEBRILE AGG is for requesting and reporting measurements of Febrile Agglutinins.
  - (8) The space marked COMP FIX is for requesting and reporting Complement Fixation Tests. The name of the specific antibody should also be written in this space.
  - (9) The space marked HAI is for requesting and reporting Hemagglutination Inhibition Tests. The name of the specific antibody should also be written in this space.
- g. SF-552 (Parasitology). Used to request tests for intestinal parasites, malaria and other blood parasites, as well as most test on feces. Fill in identification data as described previously.
- h. SF-553 (Microbiology I). Used to request most bacteriological isolations and sensitivities.
- (1) The type of the patient's infection, according to origin, is indicated by checking one of the boxes in the space marked INFECTION in the upper right area of the form.



- (2) The examination requested is indicated by checking either the box marked SMEAR, SENSITIVITY, CULTURE, or COLONY COUNT.
  - (3) The report of the examination is written or stamped on the form by the laboratory personnel.
  - (4) The names of the bacteria identified or isolated are listed in the space marked PREDOMINANT ORGANISM(S).
  - (5) The sensitivity listing and results are stamped or written in the space marked SENSITIVITY.
- i. SF-554 (Microbiology II). Used to request tests for fungi, acidfast bacillus (TB), and viruses.
    - (1) The type of infection according to origin is indicated by checking one of the boxes in the space marked INFECTION.
    - (2) The examination(s) requested is checked in the sections for fungus test or AFB tests or viral cultures.
    - (3) The test results are stamped or written on the form by the laboratory personnel.
  - j. SF-555 (Spinal Fluid). Used to request most spinal fluid tests.
  - k. SF-556 (Immunohematology). Used to request blood grouping, typing, and blood bank tests.
  - l. SF-557 (Miscellaneous). Used to request and report tests such as electrophoresis and assays of coagulation factors, which are not ordered on other laboratory forms.
    - (1) Fill in the identification data as described previously.
    - (2) The specimen source is specifically described in the space marked SPECIMEN SOURCE.
    - (3) Write the name of the test requested in the request section of the form.
21. SF-519 (Radiographic Reports). (See FIGURE 4-B-13)
- a. This is a display form for mounting Radiographic Reports (SF-519-A). Attach the SF-519-A to the indicated spaces, with the most recent report on top.
  - b. Use SF-519-A to request x-ray examinations. All patient data must be completed as indicated. Ensure that examinations requested are in standard terms or abbreviations. ALL pertinent clinical history, operations, physical findings, pregnancy status, and provisional diagnoses must be recorded in the appropriate space. This information is needed by the radiologist in order to render a proper interpretation of the film.



- c. Complete the required patient's identification information.
22. DD-771 (Eyewear Prescription). Type DD-771 for clarity and to avoid errors in interpretation, using the following format: (See FIGURE 4-B-14)
- a. Date. Enter as follows, 22 JAN 87, etc.
  - b. Order Number. Enter unit identifying number, issued by NOSTRA or Fitzsimons Army medical Center, above the order number block. Complete order number block if desired.
  - c. To. Appropriate fabricating facility.
  - d. From. Enter complete unit address of unit ordering the eyewear.
  - e. Name, Service Number/Social Security Number. Enter as ALBERT, Michael W. HSC 123-45-6789.
  - f. Age. Self-explanatory.
  - g. Unit and Address. Enter complete mailing address of unit to which individual is attached. If retiree, use the individual's home or mailing address.
  - h. Active Duty, etc. Check appropriate block.
  - i. USA, USN, etc. Check appropriate block.
  - j. Spectacles. Check appropriate block.
  - k. Aviation Spectacles. Use this block only when ordering aviation frames. Check as appropriate:
    - (1) N-15 tinted lenses;
    - (2) Coated lenses (coated with an anti-glare compound) are not authorized for Coast Guard personnel.
  - l. Other. Leave blank.
  - m. Interpupillary Distance. Copy directly from patient's Prescription, previous DD-771, or SF-600.
  - n. Eye Size. As above. (Not required for aviation goggles)
  - o. Bridge Size. As above. (Not required for aviation goggles)
  - p. Temple Length and Style. As above. (Not required for aviation goggles)
  - q. Number of Pairs. Enter the number of pairs requested.



- r. Case. Enter the number of cases requested.
- s. Single Vision.
- (1) Sphere. Copy directly from individual's prescription, previous DD-771, or SF-600 (+1.00, -1.25, etc.). Prescriptions are filled in multiples of 0.25 diopters only.
  - (2) Cylinder. As above, except that prescriptions or multivision lenses must be in "minus cylinder" form, (-0.50, -0.75, etc.).
  - (3) Axis. Copy directly from individual's prescription, previous DD-771, or SF-600. The axis must contain three (3) digits such as: 180, 090, 005, etc.
  - (4) Decentration. Need not be completed unless specified as a part of prescription.
  - (5) Prism. As indicated on individual's prescription, previous DD-771, or SF-600.
  - (6) Base. As above.
- t. Multivision. If the individual needs multivision lenses (bifocals, trifocals, etc.) then the prescription must be in minus cylinder form.
- u. Special Lenses or Frames. This block is used for special instructions or justification for aviation spectacles, or nonstandard lenses, and frames, etc.
- (1) When replacement eyewear is ordered from a prescription extracted from the health record, enter the following entry in this block: "REPLACEMENT ORDER: PRESCRIPTION FROM REFRACTION PERFORMED ON DATE."
  - (2) When eyewear is ordered for recruits, enter the following entry in this block: "RECRUIT - PLEASE EXPEDITE."
  - (3) When tinted lenses are ordered for non-aviation personnel, enter a written justification in this block. "Tinted lenses STATE JUSTIFICATION."
  - (4) When nonstandard temples or frames are ordered, enter type frame or temple requested, and justification:
    - (a) Riding Bow Cables, (Justification);
    - (b) Adjustable Nose Pads, (Justification).
  - (5) When an individual's pupillary distance is less than 60 mm it must be verified and an entry placed in this block: "PD of \_\_\_\_ verified and correct."



- v. Signature of Approving Authority. Shall be signed by the senior medical officer, designated representative, or the commanding officer where no medical officer is present.
- w. Signature of the Prescribing Officer. Shall be signed by the medical officer or person performing the refraction. When this is not possible, i.e., examination obtained from a civilian source, transcribed from the health record, etc., the person transcribing the information shall sign as prescribing officer. Flight surgeons may sign prescriptions as both the prescribing and approving authority.

23. SF-601 (Immunization Record). (See FIGURE 4-B-15)

- a. All prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, food and allergies, and blood typings shall be recorded on SF-601 and also on the PHS-731. The recordings shall be continued on the current record until additional space is required under any single category.
- b. In such cases, insert a new SF-601 in the health record and retain the old SF-601. Concurrently, make a thorough verification of the entries and bring all immunizations up-to-date. Replacement of the current SF-601 is not required because of change in grade, rating, or status of the member concerned.
- c. The name of the individual administering the immunization or test, or determining the nature of the sensitivity reaction, shall be typed or a rubber stamp used. Signatures on SF-601 are not required. However, in the event of their use, make sure they are legible.
- d. The individual administering the immunizations is responsible for completing all entries in the appropriate section, including required entries on reactions.
- e. Enter information concerning a determined hypersensitivity to an immunization or vaccine under "Remarks and Recommendations". Type appropriate entries (such as HYPERSENSITIVE TO TYPHOID) in capitals. Enter "HIV antibody testing done (enter date(s))".
- f. For Yellow Fever vaccine, record the origin and batch number.

24. SF-602 (Syphilis Record). (See FIGURE 4-B-16)

- a. This form shall be prepared and inserted in the health record for each person for whom a confirmed diagnosis of syphilis or any of its complications or sequela has been established.
- b. The medical officer shall carefully and thoroughly explain to the patient the nature of the infection and the reasons why treatment, prolonged observation and the repeated performance of certain prescribed tests are necessary. The patient shall then be requested to sign the statement in Section II of SF-602.



25. DD-1141 (Record of Occupational Exposure to Ionizing Radiation). (See FIGURE 4-B-17)

a. Requirements. The custodian of the medical records shall prepare and maintain as DD-1141 for each person occupationally exposed to ionizing radiation. Enter all exposures in rems.

b. Recording Procedures.

(1) Initial Determination of Accumulated Dose.

(a) In the initial preparation of DD-1141, obtain complete reports of previous exposure. For each period in which the individual was engaged in activities where occupational exposure was probable, and no record, or only an incomplete record of exposure during the period can be obtained, assume that an occupational exposure of 1.25 rems was incurred per quarter of each calendar year or fraction thereof.

(b) In cases where the nature of the radiation is unknown, assume gamma radiation.

(c) If an individual was exposed at more than one facility, calculate the cumulative exposures and record them in Items 7 through 12 as appropriate. Enter the sum of the whole body exposure in Item 13, and a statement regarding the sources of that information in Item 16, REMARKS.

(2) Current Record.

(a) Quarterly, make appropriate entries on each individual's DD-1141 from the exposure records received from the Public Health Service Contractor.

(b) Maintain separate DD-1141 to record exposures other than whole body, with appropriate descriptions under Item 16, REMARKS.

c. Completion Instructions.

(1) Item 1. Leave blank.

(2) Item: 2. Enter last name, first name, and middle initial. If the combination of last name and first name exceed 19 spaces, enter last name and initials only.

(3) Item 3. Enter SSN.

(4) Item: 4. Enter in not more than 10 spaces, rate, grade, title or position the individual is currently holding. Use standard service abbreviations: i.e., CAPT; HSCS; HSI; etc. Abbreviate civilian occupation titles as needed; i.e., Radiological Physicist to Rad Physic; Radiation Physiologist to Rd Physiol; Electrical Welder to Elec Wldr; etc.



- (5) Item 5. Enter date of birth: i.e., 4 SEP 87.
- (6) Item 6. Enter name of activity or unit.
- (7) Items 7 & 8. "Period of Exposure." Enter the day, month, and year: i.e., 1 MAR 87.
- (8) Items 9-12. "Dose This Period." Enter radiation dose received this period to three decimal places: i.e., 02.345rem. Use five digits including zeros as necessary for all entries.
  - (a) Item 9. Enter skin dose (soft) which includes low energy gamma and x-ray of less than 20 KVE effective energy and beta radiation. Total skin dose is the addition of columns 9 and 12.
  - (b) Item 10. Enter gamma and x-ray dose greater than 20 KVE effective energy in REM.
  - (c) Item 11. Enter neutron dose in REM.
  - (d) Item 12. Enter sum of items 10 and 11.
- (9) Item 13. Add item 12 to previous item 13; enter total in item 13.
- (10) Item 14. Enter permissible dose calculated from the age formula  $5(N-18)$  REM, where N equals the present age in years.
- (11) Item 15. Recorder certify entries by initial.
- (12) Item 16. Enter other pertinent information such as known exposure from internally deposited radioactive material or from any external radioactive sources. Describe briefly any activity or assignment bearing a potential for exposure and estimate dose-time relationships, if feasible. If this form is used for other than whole body and skin of whole body, specify the use; i.e., hands and forearms, feet and ankles, thyroid, etc. When recorded dose is not obtained from film badge readings, specify whether estimates were obtained from pocket dosimeters, area or air monitoring, bioassay, etc.

28. CG-4057 (Chronological Record of Service). (See FIGURE 4-B-18)

a. Purpose. Use this form:

- (1) to maintain a chronological record of assignments for each active duty member of the Coast Guard;
- (2) as a statement of agreement or disagreement with the assumption of fitness for duty upon separation from the Coast Guard; and
- (3) to terminate the health record.



- b. Chronological record of assignments. Prepare original only. Record the member's full name in all capitals, together with the Social Security Number. Make entries each time a member leaves or returns from PCS, TAD, or hospitalization at a unit different than the one to which currently assigned.
- c. Agreement or disagreement with the assumption of fit for duty at the time of separation. Members not already in the physical disability evaluation system, who disagree with the assumption of fitness for duty at separation shall indicate on the reverse of form CG-4057. They shall then proceed as indicated in paragraph 3-B-5. of this Manual. Members who agree with the assumption shall check the box indicating agreement. This is a health services department responsibility when there is a health services department representative attached; otherwise it becomes a personnel action.
- d. Terminating the health record. The reverse side of the form is also used to terminate a member's health record upon definite separation from active service. The date of termination is the effective date of separation. Make appropriate entries giving the reason for termination, the date of termination and the grade and signature of the responsible commissioned officer in the bottom portion of the form. Additionally, an entry, signed by the member whose health record is being terminated, acknowledging the receipt of a copy all available NAVMED 6150/20's, a copy of separation examination if done (either SF-88 or SF-600 entry), a signed copy of the CG-4057, and the PHS-731 shall be made in the Remarks section of the CG-4057.
- e. This form is also used to notify the individual of the possibility of certain disability benefit entitlements from the Department of Veterans Affairs after separation.
- f. If either side of the CG-4057 is filled, the reverse side shall have a line drawn diagonally through it in red and a second CG-4057, marked "Supplement" at the top, started.

29. NAVMED 6150/2 (Special Duty Medical Abstract). (See FIGURE 4-B-19)

- a. General. The purpose of the NAVMED 6150/2 is to provide a record of physical qualifications, special training, and periodic examinations of members designated for performing special duty, such as aviation and diving. The object of the special duty examination, and the instructions incident thereto, is to select only those individuals who are physically and mentally qualified for such special duty, and to remove from such status those members who may become temporarily or permanently unfit for such duty because of physical or mental defects. Also, in this connection, special money disbursements are often based upon the determination of a member's physical and mental qualifications or continued requalification for performing a special duty. Therefore, accuracy and content of information are essential in reporting information applicable to these categories.
- b. Entries.



- (1) Record entries upon completion of each physical examination and completion of designated special training. When a previously qualified member is suspended from special duty for physical reasons, enter the period of suspension and reason therefore on the NAVMED 6150/2.
- (2) The scope of the physical examination and technical training prescribed for these special categories often differs from the general service requirements; therefore, entries reporting results which pertain to these particular examinations or training involved shall be approved only by medical officers.

30. PHS-731 (International Certificate of Vaccination).

a. General.

- (1) Prepare PHS-731 for each member of the Coast Guard (for reserve personnel when ordered to Active Duty for Training). This form shall be carried only when performing international travel or when reporting for Active Duty for Training. When not required for either of the preceding reasons, the completed certificate shall be retained in the individual's health record. Appropriate entries shall be made on PHS-731 and SF-601 when immunizations are administered.
- (2) A reservist not on extended active duty who plans international travel either under official orders or privately, may request that the appropriate district commander (r) furnish a PHS-731 for this purpose. The reservist shall return the PHS-731 to the district commander (r) when travel is completed.
- (3) When properly completed and authenticated, the PHS-731 contains a valid certificate of immunization for international travel and quarantine purposes in accordance with World Health Organization Sanitary Regulations.
- (4) All military and nonmilitary personnel performing international travel under Coast Guard cognizance shall be immunized in accordance with Commandant Instruction 6230.4 (series) and shall have in their possession a properly completed and authenticated PHS-731.

b. Detailed Instructions.

- (1) Stamp or type the following address on the front of PHS-731:

Commandant (G-WK)  
U. S. Coast Guard  
2100 Second St., S.W.  
Washington, DC 20593-0001

- (2) Enter data by hand, rubber stamp, or typewriter.



- (3) Enter the day, month, and year in the order named (i.e., 4 SEP 87).
- (4) Record the origin and batch number for yellow fever vaccine.
- (5) Entries for cholera and yellow fever must be authenticated by the Department of Defense Immunization Stamp and the actual signature of the medical officer. Other immunizations may be authenticated by initialing. Entries based on prior official records shall have the following statement added: "Transcribed From Official Records."
- c. Remove the PHS-731 from the health record and give it to the individual upon separation from the Service.

31. CG-5214 (Emergency Medical Treatment Report). (See Figure 4-B-20)

- a. Purpose. CG-5214 provides a multiple copy record of all emergency medical care rendered by Coast Guard personnel outside of a clinic or sickbay. All care rendered by crews of Coast Guard emergency vehicles must be documented with a CG-5214.
  - (1) Part 1, Copy to Patient. This copy shall be placed in the patients' health record if available.
  - (2) Part 2, Copy to Receiving Unit. This copy shall be given to the hospital, clinic, or EMS crew assuming responsibility for patient care.
  - (3) Part 3, Copy to Triage Officer. In multi-casualty incidents, this copy shall be given to the triage officer to account for the patients' treatment priority and status. Otherwise, this copy shall be kept on file at the clinic or sickbay.
  - (4) Part 4, (hard copy) to Commandant (G-WKH-1). This copy shall be forwarded to Commandant (G-WKH-1) using the mailing label on the reverse side.
- b. Preparation and Submission of CG-5214. The form provides an accurate account of the patient's injury or illness, and a detailed report of all treatments rendered en route to a receiving facility. If possible, the report should be completed during the transport phase. Detailed instructions for completing the CG-5214 are as follows:
  - (1) Victim Identification.
    - (a) Item 1: Name. Enter last, first, and middle initial.
    - (b) Item 2: Sex. Check one.
    - (c) Item 3: Estimated Age. Enter in years or months.
  - (2) Description of Incident.
    - (a) Item 4: Date. Enter date incident occurred.



- (b) Item 5: Type of Incident. Check one and give pertinent details under "Nature of Emergency/Mechanism of Injury".
  - (c) Item 6: Time on Scene. Enter (using 24 hour clock).
  - (d) Item 7: Time of Incident. Enter (using 24 hour clock).
  - (e) Item 8: Location. Enter exact geographical area.
- (3) Observation of Victim. Stick-Man figure: Place applicable injury letter code over injured area.
  - (4) Skin. Circle applicable number.
  - (5) Vital Signs. Note time observed (24 hour clock).
  - (6) Level of Consciousness. Check only one per time observed.
  - (7) Pupils. Check only one per time observed.
  - (8) Pulse. Place numerical value under rate and check appropriate space for quality.
  - (9) Breathing. Place numerical value under rate and check appropriate space for quality.
  - (10) Blood Pressure. Enter systolic and diastolic values under applicable time.
  - (11) Temperature. Circle either oral or rectal and enter in numerical value.
  - (12) Mast. Beside "Mast BP" enter blood pressure values. Circle applicable compartments inflated.
  - (13) Triage Information. Circle one of the following:
    - (a) Priority I: Patients with airway and/or breathing problems, cardiac arrest, uncontrolled bleeding or controlled bleeding with symptoms of shock, severe head or abdominal injuries, and severe medical problems to include possible heart attack, severe burns, and severe poisonings.
    - (b) Priority II: Patients with less serious burns, multiple fractures, potential C-Spine injuries without shock, or medical conditions of a less serious note.
    - (c) Priority III: Patients with obvious minor injuries or patients who are obviously dead or mortally wounded.
  - (14) Medications. List any medications the patient is currently taking.



- (15) Allergies. List any known allergies for the patient.
- (16) Medications Administered. Note the time, dosage, and route of administration for any medications administered to the patient.
- (17) Rescuer Information.
  - (a) Item 10: Name. Enter last, first, and middle initial.
  - (b) Item 11: Level. Circle appropriate certification level.
  - (c) Item 12: Unit. Rescuer's assigned unit.
  - (d) Item 13: OPFAC#. Enter.
  - (e) Item 14: rescue Vehicle. Identity of the responding vehicle, vessel, or aircraft.
  - (f) Item 15: Receiving Unit. Hospital, EMS vehicle, or clinic assuming responsibility for patient care.
  - (g) Time Patient Transferred. Enter (24 hour clock).

32. DD877 (Request for Medical/Dental Records or Information).

- a. Purpose. The DD 877 is a self-carboning triplicate form which is used to forward health and clinical records between clinics and units as well as to request records from clinics, units, or MTFs. Shown in (Figure 4-B-21).
- b. General. This form shall be initiated and included with health and clinical records as directed in Chapter 4-A-6. And 4-D-7. Of this Manual
- c. Detailed Instruction.
  - (1) Each DD877 must have all boxes completed.
  - (2) In all instances when a DD877 is initiated, remarks concerning the reason for sending the record, the name of the gaining unit for the member/ sponsor and a request for action will be included on the form. When preparing a DD877 for a record to be forwarded, place the following in section 9., REMARKS: "Health {clinical} record for this member (family member) is forwarded to you for appropriate filing. Member (sponsor) assigned to (insert gaining unit name)."
  - (3) For members entering the inactive reserve, enter the following in section 9, remarks: "**member entering inactive reserve in your district.** Per Medical Manual, COMDTINST M6000.1B, Chapter 4-B-4.b.,this health record is forwarded for appropriate action."



- (4) A copy of the DD877 will be retained at the unit sending the record for 6 months after the record is mailed, then may be discarded.



Figure 4-B-1

# HEALTH RECORD COVER

|           |  |  |       |   |   |  |    |   |   |    |    |    |   |  |  |  |  |  |  |  |
|-----------|--|--|-------|---|---|--|----|---|---|----|----|----|---|--|--|--|--|--|--|--|
| Last Name |  |  | First |   |   | Middle   |    |   |   |    |    |    |   |  |  |  |  |  |  |  |
|           |  |  | 0     | 1 | 2 | 3  | 4  | 5   | 6 | 7  | 8  | 9  |   |  |  |  |  |  |  |  |
| 0         | Place<br>Sensitivity Sticker<br>Here<br>(if needed)  |  |       |   |   | Blood<br>Type  | Rh | Special Status  |   |    |    |    | 0 |  |  |  |  |  |  |  |
| 1         |  |  |       |   |   |  |    | <input type="checkbox"/> Aviation<br><input type="checkbox"/> OMMP<br><input type="checkbox"/> Waiver<br><input type="checkbox"/> _____ |   |    |    |    | 1 |  |  |  |  |  |  |  |
| 2         |  |  |       |   |   |  |    |   |   | YY | MM | DD | 2 |  |  |  |  |  |  |  |
| 3         |  |  |       |   |   | Date of Birth  |    |   |   |    |    |    | 3 |  |  |  |  |  |  |  |
| 4         | <b>U.S. Coast Guard</b><br><b>HEALTH RECORD</b><br><b>PRIVACY STATEMENT; HEALTH CARE RECORDS</b> |  |       |   |   |  |    |   |   |    |    |    | 4 |  |  |  |  |  |  |  |
| 5         |  |  |       |   |   | <p>1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN): Section 632 of Title14, United States Code and Section 1071-1087, Title 10 United States Code, Executive Order 9397.</p> <p>2. PRINCIPLE PURPOSE FOR WHICH INFORMATION IS TO BE USED:<br/>The purpose for requesting personal information is to assist health care personnel in developing records to facilitate and document your health in order to provide health care and to provide a complete account of such care rendered including diagnosis, treatment, and end result. The SSN is necessary to identify the person and records.</p> <p>3. ROUTINE USES: This information may be used to plan and coordinate health care. It may be used to provide health care, conduct research, teach, compile statistical data, determine suitability of persons for service or assignment, implement, preventive health and communicative disease control programs, adjudicate claims and determine benefits, evaluate care rendered, determine professional certification and hospital accreditation, conduct authorized investigations, provide physical qualifications of patients to other Federal, State, and local agencies upon request in the pursuit of their official duties, and report health conditions required by law to Federal, State, and local agencies. It may be used for other lawful purposes, including law enforcement and litigation.</p> <p>4. The above Privacy Act Statement applies to all requests for personal information made by health care personnel or for health care purposes. Failure to provide the requested information for these health records may result in an inability of Coast Guard health care personnel to afford treatment.</p> <p>5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the commanding officer for decision.</p> |    |   |   |    |    |    | 5 |  |  |  |  |  |  |  |
| 6         |  |  |       |   |   |  |    |   |   |    |    |    | 6 |  |  |  |  |  |  |  |
| 7         |  |  |       |   |   |  |    |   |   |    |    |    | 7 |  |  |  |  |  |  |  |
| 8         |  |  |       |   |   |  |    |   |   |    |    |    | 8 |  |  |  |  |  |  |  |
| 9         |  |  |       |   |   |  |    |   |   |    |    |    | 9 |  |  |  |  |  |  |  |

DEPT. OF TRANSP, USCG, CG-3443 (REV 9-92)  
PREVIOUS EDITIONS ARE OBSOLETE

SN 7530-00-F01-4180



**FIGURE 4-B-2**

| <b>ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET</b><br><i>(This form is subject to the Privacy Act of 1974 – Use DD form 2005)</i>  |  |          |  |  |       |               |               |  |
|--|--|----------|--|--|-------|---------------|---------------|--|
| <b>1. ALLERGIES</b>  |  |          |  |  |       |               |               |  |
| a. MEDICATION ALLERGIES  |  |          |  | b. OTHER ALLERGIES                           |       |               |               |  |
| <b>2. CHRONIC ILLNESS</b>  |  |          |  | <b>3. MEDICATIONS</b>                        |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
| <b>4. HOSPITALIZATIONS/SURGERIES</b>   |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
| <b>5. COUNSELING</b>   |  |          |  |  |       |               |               |  |
| F  | FITNESS  | a. DATE  |  |  |       |               |               |  |
| D  | DENTAL   | b. AGE   |  |  |       |               |               |  |
| I  | INJURY PREVENTION  | c. TOPIC |  |  |       |               |               |  |
| N  | NUTRITION/FOLATE   |          |  |  |       |               |               |  |
| C  | CANCER PREVENTION  |          |  |  |       |               |               |  |
| S  | SAFE SEX   |          |  |  |       |               |               |  |
| FP   | FAMILY PLANNING  | d. DATE  |  |  |       |               |               |  |
| Rx   | PRESENT MEDICATIONS  | e. AGE   |  |  |       |               |               |  |
| MH   | MENTAL HEALTH/STRESS/SUICIDE/<br>OCCUPATIONAL STRESS                               | f. TOPIC |  |  |       |               |               |  |
| H  | HORMONE/CALCIUM REPLACEMENT  |          |  |  |       |               |               |  |
| To   | TOBACCO  | g. DATE  |  |  |       |               |               |  |
| A  | ALCOHOL/SUBSTANCE ABUSE  | h. AGE   |  |  |       |               |               |  |
| t  | TRAVEL   | i. TOPIC |  |  |       |               |               |  |
| O.   | OCCUPATIONAL EXPOSURE (HEARING<br>THRESHOLD CHANGES/CUMULATIVE<br>TRAUMA DISORDER) |          |  |  |       |               |               |  |
|  |  | j. DATE  |  |  |       |               |               |  |
|  |  | k. AGE   |  |  |       |               |               |  |
|  |  | i. TOPIC |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
|  |  |          |  |  |       |               |               |  |
| <b>ADVANCE DIRECTIVES: DATE FILED</b>  |  |          |  |  |       |               |               |  |
| <b>PATIENT'S IDENTIFICATION</b> (Use this space for mechanical imprint)<br><br><div style="text-align: center; color: blue;"> SUPPLIED (Navy)<br/> 2766-0102-LF-984-8400, pkg-100 </div> |  |          |  | <b>RECORDS MAINTAINED AT:</b>                |       |               |               |  |
|  |  |          |  | PATIENT'S NAME                               |       |               | SEX           |  |
|  |  |          |  | LAST   | FIRST | M.I.          |               |  |
|  |  |          |  | RELATIONSHIP TO SPONSOR                      |       | STATUS        | RANK/GRADE    |  |
|  |  |          |  | SPONSOR'S NAME (Last ,First, Middle Initial) |       |               | DEPT/SERVICE  |  |
|  |  |          |  | ORGANIZATION                                 |       | SSN/ID NUMBER | DATE OF BIRTH |  |



**FIGURE 4-B-2 Con't**

| ADULT PREVENTION AND CHRONIC CARE FLOWSHEET  |   |         |   |   |   |   |   |   |   |
|--|---|---------|---|---|---|---|---|---|---|
| <b>6. FAMILY HISTORY</b> (M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather) |   |         |   |   |   |   |   |   |   |
| a. <b>CANCER</b> (Specify)   |   |         |   |   |   |   |   |   |   |
| b. <b>CARDIOVASCULAR DISEASE</b> (Specify)   |   |         |   |   |   |   |   |   |   |
| c. <b>DIABETES</b> (Specify)   |   |         |   |   |   |   |   |   |   |
| d. <b>MENTAL ILLNESS/CHEMICAL DEPENDENCY</b> (Specify)   |   |         |   |   |   |   |   |   |   |
|  |   |         |   |   |   |   |   |   |   |
| <b>7. SCREENING EXAMS</b> ( * = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, NA = Not Indicated) ( • = Next Due)            |   |         |   |   |   |   |   |   |   |
| a. TEST  | b. FREQUENCY  | c. YEAR |   |   |   |   |   |   |   |
|  |   | d. AGE  |   |   |   |   |   |   |   |
| (1) CLINICAL DISEASE PREV EVAL/PHA (HEAR)  | ANNUAL  |         | O | O | O | O | O | O | O |
| * (2) WEIGHT   | ANNUAL FOR ACTIVE DUTY  |         | O | O | O | O | O | O | O |
| * (3) HEIGHT   | ANNUAL FOR ACTIVE DUTY  |         | O | O | O | O | O | O | O |
| * (4) BLOOD PRESSURE   | ONCE q 2 YRS for BP< 130/85, ANNUAL IF GREATER  |         | O | O | O | O | O | O | O |
| * (5) CHOLESTEROL**  | *q 5 YRS FOR AGE ≥ 18 q YR if PREV ABN  |         | O | O | O | O | O | O | O |
| (6) HEARING  | CLINICAL DISCRETION   |         | O | O | O | O | O | O | O |
| (7) SKIN EXAM (Cancer)   | ANNUAL IF AT RISK   |         | O | O | O | O | O | O | O |
| (8) ORAL/DENTAL **   | ANNUAL  |         | O | O | O | O | O | O | O |
| (9) EYE/VISION **  | ROUTINE ACUITY WITH PERIODIC ASSESSMENT<br>DIABETES ANNUAL GLAUCOMA CHECK:<br>Blacks q 3-5 yrs age 20-39<br>All q 2-4 years age 40-64 |         | O | O | O | O | O | O | O |
| (10) BREAST EXAM   | ANNUAL: ≥ 40 YRS  |         | O | O | O | O | O | O | O |
| (11) MAMMOGRAM **  | BASELINE@ 40, q 2 YRS 40-50, ANNUALLY > 50  |         | O | O | O | O | O | O | O |
| (12) PAP<br>** (Digital Rectal Exam)   | BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY<br>AFTER 3 NL ANNUAL EXAMS, PERFORM q 1-3 years  |         | O | O | O | O | O | O | O |
| (13) FECAL OCCULT BLOOD  | ANNUAL ≥ 50 yrs   |         | O | O | O | O | O | O | O |
| (14) SIGMOID   | EVERY 3-5 YRS: ≥ 50 YRS   |         | O | O | O | O | O | O | O |
| (15) COLONOSCOPY   | HIGH RISK q 5 YRS ≥ YRS   |         | O | O | O | O | O | O | O |
| (16) TESTICULAR  | HIGH RISK ANNUAL 13-39 YRS  |         | O | O | O | O | O | O | O |
| (17) PROSTATE **<br>** (DIGITAL RECTAL EXAM)   | WITH P.E. ≥ 40 YRS (Presently Recommended annually)   |         | O | O | O | O | O | O | O |
| (18) RUBELLA SCREEN (Females)  | ONCE BETWEEN AGES 12-18 YRS (Unless prev vaccinated)  |         | O | O | O | O | O | O | O |
| (19) OCCUPATIONAL SCREENING EXAMS  | APPROPRIATE TO EXPOSURES  |         | O | O | O | O | O | O | O |
| (20)   |   |         | O | O | O | O | O | O | O |
| (21)   |   |         | O | O | O | O | O | O | O |
| (22)   |   |         | O | O | O | O | O | O | O |



FIGURE 4-B-2 Con't

| ADULT PREVENTION AND CHRONIC CARE FLOWSHEET   |  |                                |  |                             |  |                               |  |  |  |                                |  |
|---|--|--------------------------------|--|-----------------------------|--|-------------------------------|--|--|--|--------------------------------|--|
| <b>8. OCCUPATIONAL HISTORY/RISK</b>   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| a. PRP  |  | YES                            |  | NO                          |  |                               |  |  |  |                                |  |
| b. FLYING STATUS  |  | YES                            |  | NO                          |  |                               |  |  |  |                                |  |
| <b>9. IMMUNIZATIONS</b> <i>(Enter numeric class in sub block)</i>                               |  |                                |  |                             |  |                               |  |  |  |                                |  |
| (1) IMMUNIZATION  |  | (2) DATE<br><i>(ddmmmyyyy)</i> |  | (1) IMMUNIZATION            |  | (2) DATE<br><i>(DDMMYYYY)</i> |  | (1) IMMUNIZATION                         |  | (2) DATE<br><i>(ddmmmyyyy)</i> |  |
| a. HEP A # 1  |  |                                |  | f. MMR # 1                  |  |                               |  | j. TD <i>(q 10 YRS)</i><br><i>(Last)</i> |  |                                |  |
| b. HEP A # 2  |  |                                |  | g. MMR #2                   |  |                               |  | k. TD <i>(DUE)</i>                       |  |                                |  |
| c. HEP B # 1  |  |                                |  | h. PNEUMOCOCCUS             |  |                               |  | l. YELLOW FEVER <i>(LAST)</i>            |  |                                |  |
| d. HEP B #2   |  |                                |  | i. POLIO OPV =<br>O IPV = I |  |                               |  | m. YELLOW FEVER                          |  |                                |  |
| n. TYPHOID <i>(Enter numeric class in sub block)</i> ORAL = 0<br>TYPHUM Vi = 1. TYPHOID USP = 2 |  |                                |  | (1) DATE                    |  | (2) DATE                      |  | (3) DATE                                 |  | (4) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| O. ANTHRAX  |  | (1) INITIAL DATE               |  | (2) 2 WEEK DATE             |  | (3) 4 WEEK DATE               |  | (4) 6 MONTH DATE                         |  | (5) 12 MONTH DATE              |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| p. PPD <i>(Enter mm and date)</i>   |  | (1) (a) mm                     |  | (2) (a) mm                  |  | (3) (a) mm                    |  | (4) (a) mm                               |  | (5) (a) mm                     |  |
|   |  | (b) DATE                       |  | (b) DATE                    |  | (b) DATE                      |  | (b) DATE                                 |  | (b) DATE                       |  |
| q. INFLUENZA  |  | (1) DATE                       |  | (2) DATE                    |  | (3) DATE                      |  | (4) DATE                                 |  | (5) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| r. VARICELLA  |  | (1) DATE                       |  | (2) DATE                    |  | u. JAPANESE B ENCEPHALITIS    |  | (1) DATE                                 |  | (3) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| s. MENINGO  |  | (1) DATE                       |  | (2) DATE                    |  | v. OTHER                      |  | (1) DATE                                 |  | (2) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| t. ADENO  |  | (1) DATE                       |  | (2) DATE                    |  | w. OTHER                      |  | (1) DATE                                 |  | (2) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| <b>10. READINESS</b> <i>(Glucose-6-phosphate dehydrogenase)</i>                                 |  |                                |  |                             |  |                               |  |  |  |                                |  |
| a. DNA  |  | DATE:                          |  | b. BLOOD TYPE               |  | DATE:                         |  | c. G-PD                                  |  | DATE:                          |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| e. PERMANENT PROFILE CHANGE   |  |                                |  | (1) DATE                    |  | (2) P:                        |  | (3) U:                                   |  | (4) L:                         |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| f. GLASSES/GAS/MASK Rx:   |  | (1) DATE                       |  | (2) DATE                    |  | (3) DATE                      |  | (4) DATE                                 |  | (5) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| g. DENTAL EXAM <i>(Enter numeric class in sub block)</i>  |  | (1) DATE                       |  | (2) DATE                    |  | (3) DATE                      |  | (4) DATE                                 |  | (5) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| h. HIV TESTING  |  | (1) DATE                       |  | (2) DATE                    |  | (3) DATE                      |  | (4) DATE                                 |  | (5) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| i. FITNESS <i>(In sub block enter P = Pass, F = Fail, W = Waiver)</i>                           |  | (1) DATE                       |  | (2) DATE                    |  | (3) DATE                      |  | (4) DATE                                 |  | (5) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
|   |  | (1) DATE                       |  | (2) DATE                    |  | (3) DATE                      |  | (4) DATE                                 |  | (5) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
|   |  | (1) DATE                       |  | (2) DATE                    |  | (3) DATE                      |  | (4) DATE                                 |  | (5) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| <b>11. PRE/POST DEPLOYMENT HISTORY</b>  |  |                                |  |                             |  |                               |  |  |  |                                |  |
| a. LOCATION   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| (1) PREDEPLOYMENT   |  | (a) DATE                       |  | (b) DATE                    |  | (c) DATE                      |  | (d) DATE                                 |  | (e) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| (2) POSTDEPLOYMENT  |  | (a) DATE                       |  | (b) DATE                    |  | (c) DATE                      |  | (d) DATE                                 |  | (e) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| b. LOCATION   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| (1) PREDEPLOYMENT   |  | (a) DATE                       |  | (b) DATE                    |  | (c) DATE                      |  | (d) DATE                                 |  | (e) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| (2) POSTDEPLOYMENT  |  | (a) DATE                       |  | (b) DATE                    |  | (c) DATE                      |  | (d) DATE                                 |  | (e) DATE                       |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |
| c. CHART AUDIT  |  |                                |  |                             |  |                               |  |  |  |                                |  |
|   |  |                                |  |                             |  |                               |  |  |  |                                |  |



**FIGURE 4-B-2 Con't**

[illegible]



AUTHORIZED FOR LOCAL REPRODUCTION

SAMPLE FORM

4-48



**FIGURE 4-B-4**

|   |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|---|--|---|---|---|----------------------------|---|-------|---------|-------|--|-------------------------|-------|----|------------------------------|----|--|--|----------------|---|--------------------|-------|---|--------------------|-------|---|---------|-------|---|-------------------------|-------|---|------------------------------|----|----|----|-------|----|----|----|-------|----|----|----|-------|----|----|----|---|---|---|-------|---|---|-------|---|---|-------|---|---|-------|---|---|
| <b>MEDICAL RECORD</b>   |  | <b>REPORT OF MEDICAL EXAMINATION</b>  |   |   |                            | DATE OF EXAM  |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 1. LAST NAME – FIRST NAME- MIDDLE NAME  |  |   |   | 2. IDENTIFICATION NO.   |                            | 3. GRADE AND COMPONENT OR POSITION  |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 4. HOME ADDRESS ( <i>Number, street or RFD, city or town, state and ZIP code</i> )  |  |   |   | 5. EMERGENCY CONTACT ( <i>Name and address of contact</i> )     |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 6. DATE OF BIRTH  |  | 7. AGE  | 8. SEX<br><input type="checkbox"/> FEMALE <input type="checkbox"/> MALE |   | 9. RELATIONSHIP OF CONTACT |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 10. PLACE OF BIRTH  |  | 11. RACE<br><input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN/<br>ALASKA NATIVE <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN/PACIFIC<br>ISLANDER |   |   |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 12a. AGENCY   |  | 12b. ORGANIZATION   |   | 13. TOTAL YEARS GOVERNMENT SERVICE<br>a. MILITARY   b. CIVILIAN |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS   |  |   |   | 15. RATING OR SPECIALTY OF EXAMINER                             |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   |  |   |   | 16. PURPOSE OF EXAMINATION                                      |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| <b>#19 CLINICAL EVALUATION</b>  |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| NOR<br>MAL  | (Check each item in appropriate column; enter "NE" if not evaluated.)                          |   |   | ABNOR<br>MAL  | NOR<br>MAL                 | (Check each item in appropriate column; enter "NE" if not evaluated.)           |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | A. HEAD, FACE, NECK AND SCALP  |   |   |   |                            | O. PROSTATE ( <i>Over 40 or clinically indicated</i> )                          |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | B. EARS-GENERAL ( <i>INTERNAL CANALS</i> )<br>( <i>Auditory acuity under items 39 and 40</i> ) |   |   |   |                            | P. TESTICULAR   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | C. DRUMS   |   |   |   |                            | R. ANUS AND RECTUM ( <i>Hemorrhoids, Fistulae</i> ) ( <i>Hemocult Results</i> ) |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | D. NOSE  |   |   |   |                            | S. ENDOCRINE SYSTEM   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | E. SINUSES   |   |   |   |                            | S. G-U SYSTEM   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | F. MOUTH AND THROAT  |   |   |   |                            | T. UPPER EXTREMITIES ( <i>Strength, range of motion</i> )                       |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | G. EYES-GENERAL ( <i>Visual acuity and refraction under items 38, 39, 29, and 30</i> )         |   |   |   |                            | U. FEET   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | H. OPHTHALMOSCOPIC   |   |   |   |                            | V. LOWER EXTREMITIES ( <i>Except feet</i> )( <i>Strength range of motion</i> )  |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | I. PUPILS ( <i>Equality and reaction</i> )   |   |   |   |                            | W. SPINE, OTHER MUSCULOSKELETAL   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | J. OCULAR MOTILITY ( <i>Associated parallel movements nystagmus</i> )                          |   |   |   |                            | X. IDENTIFYING BODY MARKS, SCARS, TATTOOS                                       |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | K. LUNGS AND CHEST   |   |   |   |                            | Y. SKIN, LYMPHATICS   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | L. HEART ( <i>Thrust, size, rhythm, sounds</i> )   |   |   |   |                            | Z. NEUROLOGIC ( <i>Equilibrium tests under item 41</i> )                        |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | M. VASCULAR SYSTEM ( <i>Varicosities, etc.</i> )   |   |   |   |                            | AA. PSYCHIATRIC ( <i>Specify and personality deviation</i> )                    |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   | N. ABDOMEN AND VISCERA ( <i>Include hernia</i> )   |   |   |   |                            | BB. BREASTS   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   |  |   |   |   |                            | CC. PELVIC ( <i>Females only</i> )  |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| NOTES: ( <i>Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary.</i> )  |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 18. DENTAL ( <i>Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.</i> )   |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    | REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">/</td> <td style="text-align: center;">Non-<br/>Restorable</td> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">/</td> <td style="text-align: center;">Non-<br/>Restorable</td> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">/</td> <td style="text-align: center;">Missing</td> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">/</td> <td style="text-align: center;">Replaced<br/>by dentures</td> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">/</td> <td style="text-align: center;">Fixed<br/>Partial<br/>dentures</td> </tr> <tr> <td style="text-align: center;">32</td> <td style="text-align: center;">31</td> <td style="text-align: center;">30</td> <td style="text-align: center;">Teeth</td> <td style="text-align: center;">32</td> <td style="text-align: center;">31</td> <td style="text-align: center;">30</td> <td style="text-align: center;">Teeth</td> <td style="text-align: center;">32</td> <td style="text-align: center;">31</td> <td style="text-align: center;">30</td> <td style="text-align: center;">Teeth</td> <td style="text-align: center;">32</td> <td style="text-align: center;">31</td> <td style="text-align: center;">30</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">/</td> <td style="text-align: center;">x</td> <td style="text-align: center;">x x x</td> <td style="text-align: center;">/</td> <td style="text-align: center;">x</td> <td style="text-align: center;">x x x</td> <td style="text-align: center;">/</td> <td style="text-align: center;">x</td> <td style="text-align: center;">x x x</td> <td style="text-align: center;">/</td> <td style="text-align: center;">x</td> <td style="text-align: center;">x x x</td> <td style="text-align: center;">/</td> <td style="text-align: center;">x</td> </tr> </table> |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    |  |  | 0              | / | Non-<br>Restorable | 1 2 3 | / | Non-<br>Restorable | 1 2 3 | / | Missing | 1 2 3 | / | Replaced<br>by dentures | 1 2 3 | / | Fixed<br>Partial<br>dentures | 32 | 31 | 30 | Teeth | 32 | 31 | 30 | Teeth | 32 | 31 | 30 | Teeth | 32 | 31 | 30 | 0 | / | x | x x x | / | x | x x x | / | x | x x x | / | x | x x x | / | x |
| 0   | /  | Non-<br>Restorable  | 1 2 3   | /   | Non-<br>Restorable         | 1 2 3   | /     | Missing | 1 2 3 | /  | Replaced<br>by dentures | 1 2 3 | /  | Fixed<br>Partial<br>dentures |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 32  | 31   | 30  | Teeth   | 32  | 31                         | 30  | Teeth | 32      | 31    | 30   | Teeth                   | 32    | 31 | 30                           |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| 0   | /  | x   | x x x   | /   | x                          | x x x   | /     | x       | x x x | /  | x                       | x x x | /  | x                            |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| R   | 1  | 2   | 3   | 4   | 5                          | 6   | 7     | 8       | 9     | 10   | 11                      | 12    | 13 | 14                           | 15 | 16   |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| I   | 3  | 31  | 30  | 29  | 28                         | 27  | 26    | 25      | 24    | 23   | 22                      | 21    | 20 | 19                           | 18 | 17   |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| G   | 2  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    | L  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| H   |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    | E  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| T   |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    | F  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
|   |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| <b>19. TEST RESULTS (Copies of results are preferred as attachments)</b>  |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| A. URINALYSIS : (1) SPECIFIC GRAVITY  |  |   |   |   |                            |   |       |         |       | B. CHEST X-RAY OR PPD ( <i>Place, date, film number and result</i> ) |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| (2) URINE ALBUMIN   |  |   |   |   | (4) MICROSCOPIC            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| (3) URINE SEROLOGY  |  |   |   |   |                            |   |       |         |       |  |                         |       |    |                              |    |  |  |                |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |
| C. SYPHILIS SEROLOGY ( <i>Specify test used and results</i> )   |  |   |   |   |                            |   |       |         |       | D. EKG   |                         |       |    | E. BLOOD TYPE AND RH FACTOR  |    |  |  | F. OTHER TESTS |   |                    |       |   |                    |       |   |         |       |   |                         |       |   |                              |    |    |    |       |    |    |    |       |    |    |    |       |    |    |    |   |   |   |       |   |   |       |   |   |       |   |   |       |   |   |



**FIGURE 4-B-4 (Reverse)**

|  |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
|--|--|------------|--|--|--|----------------|--|---|---|----------------|---|--|---|--------------|--|----------------------|--|-------------------|--|-----------------|--|
| NAME   |  |            |  | IDENTIFICATION   |  |                |  | NO. OF SHEETS ATTACHED  |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| <b>MEASUREMENTS AND OTHER FINDINGS</b>   |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| 20. HEIGHT   |  | 21. WEIGHT |  | 22. COLOR HAIR   |  | 23. COLOR EYES |  | 24. BUILD<br><input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE |   |                |   | 26. TEMP   |   |              |  |                      |  |                   |  |                 |  |
| 26. BLOOD PRESSURE (Arm at heart level)  |  |            |  |  |  |                |  | 27. PULSE (Arm at heart level)  |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| A. SITTING   |  | SYS. DIAS. |  | B. RECUMBANT   |  | SYS. DIAS.     |  | C. STANDING (5 MIN)   |   | SYS. DIAS.     |   | A. SITTING   |   | B. RECUMBANT |  | C. STANDING (3 mins) |  | D. AFTER EXERCISE |  | E. 2 MINS AFTER |  |
| 28. DISTANT VISION   |  |            |  | 29. REFRACTION   |  |                |  | 30. NEAR VISION   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| RIGHT 20/  |  |            |  | CORR. TO 20/   |  |                |  | BY  |   |                |   | S.   |   |              |  | CX                   |  |                   |  |                 |  |
| LEFT 20/   |  |            |  | CORR. TO 20/   |  |                |  | BY  |   |                |   | S.   |   |              |  | CX                   |  |                   |  |                 |  |
| 31. HETEROPHORIA (Specify distance)  |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| FSO  |  | EXO        |  | R.H.   |  | L.H.           |  | PRISM DIV.  |   | PRISM CONV. CT |   | PC   |   | PD           |  |                      |  |                   |  |                 |  |
| 32. ACCOMMODATION  |  |            |  | 33. COLOR VISION (Test used and result)  |  |                |  | 34. DEPTH PERCEPTION (Test used and score)  |   |                |   | UNCORRECTED  |   |              |  |                      |  |                   |  |                 |  |
| RIGHT                  LEFT  |  |            |  |  |  |                |  |   |   |                |   | CORRECTED  |   |              |  |                      |  |                   |  |                 |  |
| 35. FIELD OF VISION  |  |            |  | 36. NIGHT VISION (Test used and SCORE)   |  |                |  | 37. RED LENS TEST   |   |                |   | 38. INTRAOCULAR TENSION                                  |   |              |  |                      |  |                   |  |                 |  |
| RIGHT                  LEFT  |  |            |  |  |  |                |  |   |   |                |   | RIGHT                  LEFT                              |   |              |  |                      |  |                   |  |                 |  |
| 39. HEARING  |  |            |  | 40. AUDIOMETER   |  |                |  |   |   |                |   | 41. PSYCHOLOGICAL AND PSYCHOMOTOR (Test used and scored) |   |              |  |                      |  |                   |  |                 |  |
| RIGHT WV                  /15   SV                  /15  |  |            |  | 250                  500                  1000                  2000                  3000                  4000                  6000                  8000 |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
|  |  |            |  | 256                  512                  1024                  2048                  2896                  4096                  6144                  8192 |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
|  |  |            |  | RIGHT  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| LEFT WV                  /15   SV                  /15   |  |            |  | LEFT   |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| 42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY.   |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
|  |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| (Use additional sheets if necessary)   |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| 44. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)  |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
|  |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| 44. RECOMMENDATIONS-FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)  |  |            |  |  |  |                |  | 45A. PHYSICAL PROFILE   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
|  |  |            |  |  |  |                |  | P   | U | L              | H | E  | S |              |  |                      |  |                   |  |                 |  |
| 46. EXAMINEE (CHECK)<br>A. <input type="checkbox"/> IS QUALIFIED FOR<br>B. <input type="checkbox"/> IS NOT QUALIFIED FOR |  |            |  |  |  |                |  | 45B. PHYSICAL CATEGORY  |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
|  |  |            |  |  |  |                |  | A   | B | C              | E |  |   |              |  |                      |  |                   |  |                 |  |
| 47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER  |  |            |  |  |  |                |  |   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| 48. TYPED OR PRINTED NAME OF PHYSICIAN   |  |            |  |  |  |                |  | SIGNATURE   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| 49. TYPED OR PRINTED NAME OF PHYSICIAN   |  |            |  |  |  |                |  | SIGNATURE   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| 50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)   |  |            |  |  |  |                |  | SIGNATURE   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |
| 51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY  |  |            |  |  |  |                |  | SIGNATURE   |   |                |   |  |   |              |  |                      |  |                   |  |                 |  |



**FIGURE 4-B-5**

| MEDICAL RECORD   |  |           |    | REPORT OF MEDICAL HISTORY |   |  |     | DATE OF EXAM |                    |  |  |     |    |            |
|--|--|-----------|----|---------------------------|---|--|-----|--------------|--------------------|--|--|-----|----|------------|
| <b>NOTE: this information is for official and medically-confidential use only and will not be released to unauthorized persons</b> |  |           |    |                           |   |  |     |              |                    |  |  |     |    |            |
| 1 NAME OF PATIENT ( <i>Last,first,middle</i> )   |  |           |    |                           |   | 2. IDENTIFICATION NUMBER   |     |              | 3. GRADE           |  |  |     |    |            |
| 4a. HOME ADDRESS ( <i>Street or RFD; City or Town: State; and ZIP code</i> )   |  |           |    |                           |   | 5. EXAMINING FACILITY  |     |              |                    |  |  |     |    |            |
| 4b. CITY   |  | 4c. STATE |    | 4d Zip Code               |   |  |     |              |                    |  |  |     |    |            |
| 6. PURPOSE OF EXAMINATION  |  |           |    |                           |   |  |     |              |                    |  |  |     |    |            |
| 7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED ( <i>Use additional pages if necessary</i> )               |  |           |    |                           |   |  |     |              |                    |  |  |     |    |            |
| a. PRESENT HEALTH  |  |           |    |                           |   | b. CURRENT MEDICATION  |     |              | REGULAR OR INTERM. |  |  |     |    |            |
|  |  |           |    |                           |   |  |     |              |                    |  |  |     |    |            |
|  |  |           |    |                           |   |  |     |              |                    |  |  |     |    |            |
|  |  |           |    |                           |   |  |     |              |                    |  |  |     |    |            |
| c. ALLERGIES ( <i>Include insect bites/stings and common foods</i> )   |  |           |    |                           |   | d. HEIGHT  |     |              | e. WEIGHT          |  |  |     |    |            |
| 8. PATIENT'S OCCUPATION  |  |           |    |                           |   | 9. ARE YOU ( <i>Check one</i> )  |     |              |                    |  |  |     |    |            |
|  |  |           |    |                           |   | <input type="checkbox"/> LEFT HANDED <input type="checkbox"/> RIGHT HANDED |     |              |                    |  |  |     |    |            |
| 10. LIST CURRENT MEDICAL HISTORY   |  |           |    |                           |   |  |     |              |                    |  |  |     |    |            |
| CHECK EACH ITEM  |  | YES       | NO | DON'T KNOW                | CHECK EACH ITEM                           |  | YES | NO           | DON'T KNOW         | CHECK EACH ITEM  |  | YES | NO | DON'T KNOW |
| Household contact with anyone with tuberculosis  |  |           |    |                           | Shortness of breath                       |  |     |              |                    | Bone, joint or other deformity                               |  |     |    |            |
|  |  |           |    |                           | Pain or pressure in chest                 |  |     |              |                    | Loss of finger or toe  |  |     |    |            |
| Tuberculosis or positive TB test   |  |           |    |                           | Chronic cough                             |  |     |              |                    | Painful or "trick" shoulder or elbow                         |  |     |    |            |
| Blood in sputum or when coughing   |  |           |    |                           | Palpitation or pounding heart             |  |     |              |                    | Recurrent back pain or any back injury                       |  |     |    |            |
| Excessive bleeding after injury or dental work   |  |           |    |                           | Heart trouble                             |  |     |              |                    | "Trick" or locked knee                                       |  |     |    |            |
| Suicide attempt or plans   |  |           |    |                           | High or low blood pressure                |  |     |              |                    | Foot trouble   |  |     |    |            |
| Sleepwalking   |  |           |    |                           | Cramps in your legs                       |  |     |              |                    | Nerve injury   |  |     |    |            |
| Wear corrective lenses   |  |           |    |                           | Frequent indigestion                      |  |     |              |                    | Paralysis ( <i>include infantile</i> )                       |  |     |    |            |
| Eye surgery to correct vision  |  |           |    |                           | Stomach, liver, or intestinal trouble     |  |     |              |                    | Epilepsy or seizure  |  |     |    |            |
| Lack vision in either eye  |  |           |    |                           | Gall bladder trouble or gallstones        |  |     |              |                    | Car, train, sea or air sickness                              |  |     |    |            |
| Wear a hearing aid   |  |           |    |                           | Jaundice or hepatitis                     |  |     |              |                    | Frequent trouble sleeping                                    |  |     |    |            |
| Stutter or stammer   |  |           |    |                           | Broken bones                              |  |     |              |                    | Depression or excessive worry                                |  |     |    |            |
| Wear a brace or back support   |  |           |    |                           | Adverse reaction to medication            |  |     |              |                    | Loss of memory or amnesia                                    |  |     |    |            |
| Scarlet fever  |  |           |    |                           | Skin diseases                             |  |     |              |                    | Nervous trouble of any sort                                  |  |     |    |            |
| Rheumatic fever  |  |           |    |                           | Tumor, growth, cyst, cancer               |  |     |              |                    | Periods of unconsciousness                                   |  |     |    |            |
| Swollen or painful joints  |  |           |    |                           | Hernia                                    |  |     |              |                    | Parent/sibling with diabetes cancer, stroke or heart disease |  |     |    |            |
| Frequent or severe headaches   |  |           |    |                           | Hemorrhoids or rectal disease             |  |     |              |                    | X-ray or other radiation therapy                             |  |     |    |            |
| Dizziness or fainting spells   |  |           |    |                           | Frequent or painful urination             |  |     |              |                    | Chemotherapy   |  |     |    |            |
| Eye trouble  |  |           |    |                           | Bed wetting since age 12                  |  |     |              |                    | Asbestos or toxic chemical exposure                          |  |     |    |            |
| Hearing loss   |  |           |    |                           | Kidney stone or blood in urine            |  |     |              |                    | Plate, pin or rod in any bone                                |  |     |    |            |
| Recurrent ear infections   |  |           |    |                           | Sugar or albumin in urine                 |  |     |              |                    | Easy fatigability  |  |     |    |            |
| Chronic or frequent colds  |  |           |    |                           | Sexually transmitted disease              |  |     |              |                    | Been told to cut down or criticized for alcohol use          |  |     |    |            |
| Severe tooth or gum trouble  |  |           |    |                           | Recent gain or loss of weight             |  |     |              |                    | Used illegal substances                                      |  |     |    |            |
| Sinusitis  |  |           |    |                           | Eating disorder (anorexia, bulimia, etc.) |  |     |              |                    | Used tobacco   |  |     |    |            |
| Hay Fever or allergic rhinitis   |  |           |    |                           | Arthritis, Rheumatism or Bursitis         |  |     |              |                    |  |  |     |    |            |
| Head injury  |  |           |    |                           | Thyroid trouble or goiter                 |  |     |              |                    |  |  |     |    |            |
| Asthma   |  |           |    |                           |   |  |     |              |                    |  |  |     |    |            |

NSN 7540-00-181-8638  
Previous edition not usable

**STANDARD FORM 93** (REV.6/96) (EG)  
Prescribed by ICMR/GSA  
FIRM (41 CFR) 201-9.202-1  
Designed using Perform Pro, WHS/DIOR, Apr 97



FIGURE 4-B-5 (reverse) SF 93 History

| 11. FEMALES ONLY   |     |    |  |                               |                        |                       |
|--|-----|----|--|-------------------------------|------------------------|-----------------------|
| Check each item  | YES | NO | DON'T KNOW   | DATE OF LAST MENSTRUAL PERIOD | DATE OF LAST PAP SMEAR | DATE OF LST MAMMOGRAM |
| Treated for a female disorder  |     |    |  |                               |                        |                       |
| Changed in menstrual pattern   |     |    |  |                               |                        |                       |
| CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.  |     |    |  |                               |                        |                       |
| ITEM   | YES | NO | <div style="text-align: center; font-size: 2em; color: blue; transform: rotate(-10deg); opacity: 0.5;">SAMPLE FORM</div> |                               |                        |                       |
| 12. Have you been refused employment or been unable to hold a job or stay in school because of:  |     |    |  |                               |                        |                       |
| a. Sensitivity to chemicals, dust, sunlight, etc.  |     |    |  |                               |                        |                       |
| b. Inability to perform certain motions.   |     |    |  |                               |                        |                       |
| c. Inability to assume certain positions.  |     |    |  |                               |                        |                       |
| d. Other medical reason (If yes, give reasons.)  |     |    |  |                               |                        |                       |
| 13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)  |     |    |  |                               |                        |                       |
| 14. Have you ever been denied life insurance? (If yes, state reason and give details)  |     |    |  |                               |                        |                       |
| 15. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred)   |     |    |  |                               |                        |                       |
| 16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)   |     |    |  |                               |                        |                       |
| 17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)   |     |    |  |                               |                        |                       |
| 18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)  |     |    |  |                               |                        |                       |
| 19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)  |     |    |  |                               |                        |                       |
| 20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)  |     |    |  |                               |                        |                       |
| 21. Have you ever been arrested or convicted of a crime, other than minor traffic violations? (If yes, provide details.)   |     |    |  |                               |                        |                       |
| 22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)  |     |    |  |                               |                        |                       |
| 23. LIST ALL IMMUNIZATIONS RECEIVED  |     |    |  |                               |                        |                       |
| I certify that I have received the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment. |     |    |  |                               |                        |                       |
| 24a. TYPED OR PRINTED NAME OF EXAMINEE   |     |    | 24b. SIGNATURE   |                               |                        | 24c. DATE             |
| <b>NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."</b>   |     |    |  |                               |                        |                       |
| 25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (physician shall comment on all positive answers in item 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)  |     |    |  |                               |                        |                       |
| 26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER  |     |    | 26b. SIGNATURE   |                               |                        | 26 c. DATE            |

STANDARD FORM 93 (REV.6-96) BACK



FIGURE 4-B-6

| NSN 7540-01-075-3786  |                  |   |   |  |                          |
|---|------------------|---|---|--|--------------------------|
| <b>MEDICAL RECORD</b>   |                  | <b>EMERGENCY CARE<br/>AND TREATMENT<br/>(Patient)</b>   |   | LOG NUMBER   | TREATMENT FACILITY       |
|   |                  |   |   | RECORDS MAINTAINED AT  |                          |
| PATIENT'S HOME ADDRESS OR DUTY STATION  |                  |   |   | <b>ARRIVAL</b>   |                          |
| STREET ADDRESS  |                  |   |   | DATE (Day, Month, Year)  | TIME                     |
| CITY  |                  | STATE   | ZIP CODE  | TRANSPORTATION TO FACILITY   |                          |
| SEX   | DUTY/LOCAL PHONE |   | MILITARY STATUS   |  | THIRD PARTY INSURANCE    |
|   | AREA CODE        | NUMBER  | ITEM  | YES  | NO                       |
| AGE   | HOME PHONE       |   | FLYING STATUS   | DD 2568 IN CHART   |                          |
|   | NUMBER           | MEDICAL HISTORY OBTAINED FROM   |   | NAME OF INSURANCE COMPANY  |                          |
| CURRENT MEDICATIONS   |                  | <b>INJURY OR OCCUPATIONAL ILLNESS</b>   |   | <b>EMERGENCY ROOM VISIT</b>  |                          |
|   |                  | YES   | NO  | WHEN (DATE)  | DATE LAST VISIT          |
| ALLERGIES   |                  | IS THIS AN INJURY   |   | TETANUS  |                          |
|   |                  | INJURY/SAFETY FORMS HOW   | WHERE   | DATE LAST SHOT   | COMPLETED INITIAL SERIES |
| CHIEF COMPLAINT   |                  |   |   |  |                          |
| <b>CATEGORY OF TREATMENT</b>  |                  |   | <b>VITAL SIGNS</b>  |  |                          |
| <input type="checkbox"/> EMERGENT<br><input type="checkbox"/> URGENT<br><input type="checkbox"/> NON-URGENT   |                  |   | TIME  |  |                          |
|   |                  |   | INITIALS  |  |                          |
| <b>LAB ORDERS</b><br><div style="display: flex; justify-content: space-between;"> <div> CBC/DIFF<br/>URINE C&amp;S<br/>BLOOD C&amp;S X </div> <div> ABG<br/>UA </div> <div> PT/PTT </div> <div> BHC/G/URINE/BLOOD/QUANT<br/>CHEM: </div> </div> |                  |   | <b>X-RAY ORDERS</b><br><div style="display: flex; justify-content: space-between;"> <div> CXR PA &amp; LAT/PORTABLE<br/>ACUTE ABDOMEN<br/>ANKLE R/L </div> <div> C-SPINE<br/>LS SPINE<br/>HEAD CT </div> </div> |  |                          |
|   |                  |   |   |  |                          |
|   |                  |   |   |  |                          |
|   |                  |   |   |  |                          |
| <b>ORDERS</b>   |                  |   |   |  |                          |
| <input type="checkbox"/> PULSE OX <input type="checkbox"/> MONITOR <input type="checkbox"/> ECG   |                  |   |   |  |                          |
| TIME  | ORDERS           | BY  | COMPLETED BY  | TIME   | PATIENT'S RESPONSE       |
|   |                  |   |   |  |                          |
|   |                  |   |   |  |                          |
| DISPOSITION   |                  | DISPOSITION QUARTERS/OFF DUTY   |   | PATIENT/DISCHARGE INSTRUCTIONS   |                          |
| <input type="checkbox"/> HOME <input type="checkbox"/> FULL DUTY<br>MODIFIED DUTY UNTIL   |                  | <input type="checkbox"/> 24 HRS. <input type="checkbox"/> 48 HRS. <input type="checkbox"/> 78 HRS<br>RETURN TO DUTY |   |  |                          |
| CONDITION UPON RELEASE  |                  | ADMIT TO UNIT/SERVICE   |   | REFERRED   | TO                       |
| <input type="checkbox"/> IMPROVED <input type="checkbox"/> UNCHANGED<br><input type="checkbox"/> DETERIORATED   |                  | TIME OF RELEASE   |   | <b>I have received and understand these instructions.</b><br>PATIENT'S SIGNATURE |                          |
| PATIENT'S IDENTIFICATION (For typed or written entries, give: name-last, first, middle; ID no. (SSN or other); hospital or medical facility)  |                  |   |   |  |                          |

EMERGENCY CARE AND TREATMENT (Patient)

MEDICAL RECORD

STANDARD FORM 558 (REV 9-96)

Prescribed by GSA/ICMR

FPMR (41 CFR) 101-11.203(b)(10)



FIGURE 4-B-6 (*Doctors notes*)

NSN 7540-01-075-3786

|                           |     |  |      |     |  |                       |     |                  |                                    |                          |
|---------------------------|-----|--|------|-----|--|-----------------------|-----|------------------|------------------------------------|--------------------------|
| <b>MEDICAL RECORD</b>     |     | <b>EMERGENCY CARE AND TREATMENT<br/>(Doctor)</b> |      |     |  | TIME SEEN BY PROVIDER |     |                  |                                    |                          |
| <b>TEST RESULTS</b>       |     |  |      |     |  |                       |     |                  |                                    |                          |
| CBC                       | WBC | SMAC   |      |     |  | ABG/PULSE OX          |     | <b>RADIOLOGY</b> | CHECK IF<br>READ BY<br>RADIOLOGIST | <input type="checkbox"/> |
|                           | H/H |  |      |     |  | SUP 02                | PH  |                  |                                    |                          |
|                           | PLT |  |      |     |  | PCO2                  | SAT | OTHER            | EKG INTERPRETATION                 |                          |
|                           | PT  |  |      |     |  | U/A                   | DIP |                  |                                    |                          |
| APTT                      |     | BHCG   | ETOH | GLU |  | MICRO                 |     |                  |                                    |                          |
| PROVIDER HISTORY/PHYSICAL |     |  |      |     |  |                       |     |                  |                                    |                          |

SAMPLE FORM

|              |      |        |  |  |
|--------------|------|--------|--|--|
| CONSULT WITH | TIME | ACTION | RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP |  |
|              |      |        |  |  |
|              |      |        |  |  |
|              |      |        |  |  |
|              |      |        | PROVIDER SIGNATURE AND STAMP                 |  |
|              |      |        |  |  |
| DIAGNOSIS    |      |        | CODES  |  |
|              |      |        |  |  |

PATIENT'S IDENTIFICATION (*For typed or written entries, give: Name-last, first ,middle;  
ID no. (SSN or other); hospital or medical facility*)

**EMERGENCY CARE AND TREATMENT (Doctor)**  
 MEDICAL RECORD  
**STANDARD FORM 558 (REV 9-96)**  
 Prescribed by GSA/ICMR  
 FPMR (41 CFR) 101-11.203(b)(10)



**FIGURE 4-B-7**

|  |                   |  |                             |
|--|-------------------|--|-----------------------------|
| <b>MEDICAL RECORD</b>  |                   | <b>NARRATIVE SUMMARY (CLINICAL RESUME)</b> |                             |
| DATE OF ADMISSION  | DATE OF DISCHARGE |  | NUMBER OF DAYS HOSPITALIZED |
| <p style="text-align: center;">(Sign and date at end of narrative)</p> <p style="font-size: 100px; color: blue; opacity: 0.5; transform: rotate(-20deg); position: absolute; top: 30%; left: 30%;">SAMPLE FORM</p> |                   |  |                             |
| SIGNATURE OF PHYSICIAN   |                   | DATE                                       | IDENTIFICATION NO.          |
| PATIENT'S IDENTIFICATION   |                   | REGISTER NO.                               |                             |
| (For typed or written entries give: Name last, first; middle; grade; rank; rate ;hospital or medical facility)   |                   | WARD NO.                                   |                             |

**NARRATIVE SUMMARY (CLINICAL RESUME)**

**MEDICAL RECORD**  
 STANDARD FORM 502 (rev-7-91)  
 Prescribed by GSA/ICMR, FIRMR  
 (41-CFR) 201-9.202.1



FIGURE 4-B-8

|  |   |  |   |
|--|---|--|---|
| <b>MEDICAL RECORD</b>  |   | <b>CONSULTATION SHEET</b>  |   |
| <b>REQUEST</b>   |   |  |   |
| TO:  |   | FROM: <i>(requesting physician or activity)</i>  | DATE OF REQUEST   |
| REASON FOR REQUEST <i>(Complaints and findings)</i>  |   |  |   |
| PROVISIONAL DIAGNOSIS  |   |  |   |
| DOCTOR'S SIGNATURE   | APPROVED                                    | PLACE OF CONSULTATION<br><input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL | <input type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY<br><input type="checkbox"/> 72 HOURS <input type="checkbox"/> EMERGENCY |
| <b>CONSULTATION REPORT</b>   |   |  |   |
| RECORD REVIEWED <input type="checkbox"/> YES <input type="checkbox"/> NO                      PATIENT EXAMINED <input type="checkbox"/> YES <input type="checkbox"/> NO                      TELEMEDICINE <input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |   |
| SAMPLE FORM  |   |  |   |
| SIGNATURE AND TITLE  |   |  | DATE  |
| HOSPITAL OR MEDICAL FACILITY   | RECORDS MAINTAINED AT                       | DEPARTMENT/SERVICE OF PATIENT  |   |
| RELATION TO SPONSOR  | SPONSOR'S NAME <i>(last, first, middle)</i> | SPONSOR'S ID NUMBER  |   |
| PATIENT'S IDENTIFICATION <i>(For typed or written entries, give: Name –last, first, middle; ID No.(SSN or other); Sex; Date of Birth; Rank/Grade)</i>  |   | REGISTER NO.   | WARD NO.  |

**CONSULTATION SHEET**  
MEDICAL RECORD  
STANDARD FORM 513 (Rev. 4-98)  
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)



**FIGURE 4-B-9**

|  |     |                        |        |      |                                    |  |  |  |   |  |  |
|--|-----|------------------------|--------|------|------------------------------------|--|--|--|---|--|--|
| <b>Clinical Record</b>   |     |                        |        |      | <b>ELECTROCARDIOGRAPHIC RECORD</b> |  |  |  |   | Previous ECG<br><input type="checkbox"/> Yes <input type="checkbox"/> NO |  |
| Clinical Impression  |     |                        |        |      | Medication                         |  | <input type="checkbox"/> Emergency<br><input type="checkbox"/> Routine |  | <input type="checkbox"/> Bedside<br><input type="checkbox"/> Ambulant |  |  |
| Age  | Sex | Race                   | Height | B.P. | Signature of Ward Physician        |  |  |  | Date  |  |  |
| Rhythm   |     |                        |        |      | Axis Deviation                     |  |  | Rates<br>Auric.                      Vent. |   |  |  |
| Intervals<br>PR                      QRS                      QT   |     |                        |        |      | P Waves                            |  |  |  |   |  |  |
| QRS Complexes  |     |                        |        |      |                                    |  |  |  |   |  |  |
| RS-T Segment   |     |                        |        |      | T Waves                            |  |  |  |   |  |  |
| Unipolar Extremity Leads ( <i>specify</i> )  |     |                        |        |      |                                    |  |  |  |   |  |  |
| Precordial Leads ( <i>specify</i> )  |     |                        |        |      |                                    |  |  |  |   |  |  |
| Summary, Serial Changes, and Implications:   |     |                        |        |      |                                    |  |  |  |   |  |  |
| (Continue on Reverse)  |     |                        |        |      |                                    |  |  |  |   |  |  |
| No.<br><br>ECG   |     | Signature of Physician |        |      | Patient's Identification No.       |  |  |  | Date  |  |  |
| Patient's Identification (For typed or written entries give; Name – Last<br>First, middle; grade, date hospital or medical facility) |     |                        |        |      | Register No.                       |  |  |  | Ward No.  |  |  |

Electrocardiographic Records  
Standard Form 520  
General Services Administration and  
Interagency Committee on Medical Records  
FPMR 101-11.806-8  
October 1975 520-106



FIGURE 4-B-10

AUTHORIZED FOR LOCAL REPRODUCTION

|  |  |   |               |
|--|--|---|---------------|
| <b>MEDICAL RECORD</b>  |  | <b>TISSUE EXAMINATION</b>                 |               |
| SPECIMEN SUBMITTED BY  |  |   | DATE OBTAINED |
| SPECIMEN   |  |   |               |
| BRIEF CLINICAL HISTORY <i>(include duration of lesion and rapidity of growth, if a neoplasm)</i>   |  |   |               |
| PREOPERATIVE DIAGNOSIS   |  |   |               |
| OPERATIVE FINDINGS   |  |   |               |
| POSTOPERATIVE DIAGNOSIS  |  | SIGNATURE                                 |               |
|  |  | NAME OF SIGNER                            |               |
|  |  | TITLE OF SIGNER                           |               |
| <b>PATHOLOGICAL REPORT</b>   |  |   |               |
| NAME OF LABORATORY   |  | ACCESSION NO(S)                           |               |
|  |  |   |               |
| GROSS DESCRIPTION, HISTOLOGIC EXAMINATION AND DIAGNOSES  |  |   |               |
| <div style="color: blue; font-size: 2em; transform: rotate(-15deg); opacity: 0.5;">SAMPLE FORM</div>   |  |   |               |
| SIGNATURE OF PATHOLOGIST   |  | NAME OF PATHOLOGIST                       | DATE          |
| HOSPITAL OR MEDICAL FACILITY   | RECORDS MAINTAINED AT                      | DEPARTMENT/SERVICE OF PATIENT             |               |
| RELATION TO SPONSOR  | SPONSOR'S NAME <i>(Last, first middle)</i> | SPONSOR'S ID NUMBER <i>(SSN or Other)</i> |               |
| PATIENT'S IDENTIFICATION <small>(For typed or written entries, give: Name-last, first, middle; ID no. SSN or other); Sex; Date of Birth; Rank/Grade)</small> |  | REGISTER NO.                              | WARD NO.      |

**TISSUE EXAMINATION**  
Medical Record

**STANDARD FORM 515** (Rev 8-97)  
Prescribed by GSA/ICMR FPMR 101-11.203(b)(10)



**FIGURE 4-B-11**

|  |   |                             |                     |   |  |                                      |          |
|--|---|-----------------------------|---------------------|---|--|--------------------------------------|----------|
| <b>Medical record</b>  |   | <b>GYNECOLOGIC CYTOLOGY</b> |                     |   |  |                                      |          |
| <b>Section I – Clinical data to be Completed by Examining Installation</b>   |   |                             |                     |   |  |                                      |          |
| Date Obtained  |   |                             | LMP First Day       |   |  | Date Received in Laboratory          |          |
| Source of Specimen<br><input type="checkbox"/> Combined Cerve and Vagina <input type="checkbox"/> Cerve <input type="checkbox"/> Vagina <input type="checkbox"/> Other (Specify) |   |                             |                     |   |  |                                      |          |
| Age  | Pregnancy<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                             | Gravida             | Para  | Previous Abnormal Cytologic Examination<br><input type="checkbox"/> Yes, Give Date _____ <input type="checkbox"/> No |                                      |          |
| Clinical History ( <i>Surgery, Drugs, hormones, radiation, etc.</i> )  |   |                             |                     | Physical Examination ( <i>Pelvic findings, etc.</i> ) |  |                                      |          |
| Specimen Submitted By ( <i>Facility</i> )  |   |                             | Signature and title |   |  | Submitting Facility Accession Number |          |
| <b>Section II – Cytologic Findings Form Reporting Installation Only</b>  |   |                             |                     |   |  |                                      |          |
| Name of Laboratory   |   |                             |                     |   | Accession Number   |                                      |          |
| Check One  | Yes   | No                          | Check One           | Yes   | No   |                                      |          |
| Granulocytes   |   |                             | Endocervial Cells   |   |  | Maturation Index                     |          |
| Leukocytes   |   |                             |                     |   |  | Parabasals                           |          |
| Trichomonas  |   |                             | Screened By         |   |  | Intermediates                        |          |
| Candida  |   |                             |                     |   |  | Superficials                         |          |
| Comments and recommendations   |   |                             |                     |   |  |                                      |          |
| <div style="font-size: 4em; color: blue; opacity: 0.5; transform: rotate(-15deg);">SAMPLE FORM</div>   |   |                             |                     |   |  |                                      |          |
| Pathologist's Signature  |   |                             | Title               |   |  | Date                                 |          |
| Patients Identification (For typed or written entries give; Name – Last first, Middle; grade, date, hospital or medical facility)  |   |                             |                     |   | Register No.   |                                      | Ward No. |

**Standard form 541  
Provided by GSA and ICMB**



FIGURE-4-B-12




| CLINICAL RECORD   |  | LABORATORY REPORTS  |          |
|---|--|---|----------|
|   |  |   |          |
|   |  |   |          |
|   |  |   |          |
|   |  |   |          |
|   |  |   |          |
|   |  |   |          |
|   |  |   |          |
|   |  |   |          |
|   |  | ATTACH 3D REPORT ALONG HERE AND ↖ SUCCEEDING ONES ON ABOVE LINES        |          |
|   |  | ATTACH 2D REPORT WITH TOP AT THIS LINE ↖                                |          |
|   |  | ATTACH 1 <sup>ST</sup> REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↖ |          |
| ATTACHING MARGIN  |  |   |          |
| ATTACH ALL TEST REPORTS TO THIS SHEET   |  |   |          |
| PATIENT'S IDENTIFICATION <small>(For typed or written entries give: Name - Last, first, middle; grade; date; hospital or medical facility),</small> |  | REGISTER NO.  | WARD NO. |

LABORATORY REPORTS

Standard Form 514  
Prescribed by GSA/ICMR  
FIRMR (41 CFR) 201-45.505  
October 1975 514-108



**FIGURE 4-B-13**

| MEDICAL RECORD                    | RADIOLOGICAL CONSULTATION REQUESTS/REPORTS   |
|-----------------------------------|--|
|                                   |  |
|                                   |  |
|                                   |  |
|                                   |  |
|                                   |  |
|                                   |  |
|                                   | ATTACH 3D REPORT ALONG HERE  AND SUCCEEDING ONES ON ABOVE LINES           |
|                                   | ATTACH 2D REPORT WITH TOP AT THIS LINE                                  |
| ATTACH REPORTS WITHIN THIS MARGIN | ATTACH 1 <sup>ST</sup> REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE  |

SAMPLE FORM

**RADIOLOGICAL CONSULTATIONS  
REQUESTS/REPORTS  
STANDARD FORM 519** (Rev. 2-84)  
Prescribed by GSA/ICMR  
FIRMR (41 CFR) 201.45.505  
519-11  
NSN 7540-00-634-4160



**FIGURE 4-B-14**

(THIS FORM IS SUBJECT TO THE  
PRIVACY ACT OF 1974 –  
Use DD Form 2006.)

|   |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
|---|--|----------|--|----------------|--|-----------------------|--|---|--|---------------------|--|------------------|--|--------|--|----------------------|--|----|--|-------------|--|-------------|--|
| <b>EYEWEAR<br/>PRESCRIPTION</b>   |  |          |  | <b>DATE</b>    |  | <b>ACCOUNT NUMBER</b> |  |   |  | <b>ORDER NUMBER</b> |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>TO: (LAB)</b>  |  |          |  |                |  | <b>FROM:</b>          |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>NAME (Last, First)</b>   |  |          |  |                |  | <b>SSN</b>            |  |   |  | <b>GRADE</b>        |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>ADDRESS/UNIT</b>   |  |          |  |                |  |                       |  | <b>PHONE</b>  |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>ADDRESS CONTINUED</b>  |  |          |  |                |  |                       |  | <b>SHIP TO:</b><br><input type="checkbox"/> <b>CLINIC</b> <input type="checkbox"/> <b>PATIENT</b> |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>CITY, STATE, ZIP</b>   |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| AD  |  | RES      |  | NG             |  | RET                   |  | OTHER   |  | A                   |  | N                |  | AF     |  | MC                   |  | CG |  | PHS         |  | OTHER       |  |
|   |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>FRAME</b>  |  |          |  | <b>EYE</b>     |  |                       |  | <b>BRIDGE</b>   |  |                     |  | <b>TEMPLE</b>    |  |        |  | <b>COLOR</b>         |  |    |  |             |  |             |  |
| <b>DIST</b>   |  |          |  | <b>NEAR</b>    |  |                       |  | <b>LENS</b>   |  |                     |  | <b>TINT</b>      |  |        |  | <b>MATERIAL</b>      |  |    |  | <b>PAIR</b> |  | <b>CASE</b> |  |
| <b>PD</b>   |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| SPHERE  |  | CYLINDER |  | AXIS           |  | DECENTER              |  | H PRISM   |  | H BASE              |  | V PRISM          |  | V BASE |  |                      |  |    |  |             |  |             |  |
| <b>R</b>  |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>L</b>  |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>MULTIVISION</b>  |  |          |  |                |  |                       |  |   |  | <b>LAB USE</b>      |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| NEAR ADD  |  | SEG HT   |  | TOTAL DECENTER |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
|   |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
|   |  |          |  |                |  |                       |  |   |  | <b>PRIORITY</b>     |  |                  |  |        |  | <b>TECH INITIALS</b> |  |    |  |             |  |             |  |
| <b>SPECIAL COMMENTS/JUSTIFICATION (* Use this space to specify blocks marked "Other.")</b>                              |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |
| <b>PRESCRIBING OFFICER/AUTHORITY</b>  |  |          |  |                |  |                       |  |   |  |                     |  | <b>SIGNATURE</b> |  |        |  |                      |  |    |  |             |  |             |  |
| <b>DISTRIBUTION: ORIGINAL – Retained by Lab.   COPY 1 – Returned with eyewear.   COPY 2 – Entered in health record.</b> |  |          |  |                |  |                       |  |   |  |                     |  |                  |  |        |  |                      |  |    |  |             |  |             |  |

**DD FORM 771, JUL 96 (EG)**

PREVIOUS EDITION IS

Designed using Perform Pro, WHS/DIOR, Aug 96



FIGURE 4-B-15

| HEALTH RECORD  |      | IMMUNIZATION RECORD |                  |          |                  | <i>All entries in ink to be made in block letters</i> |                  |
|--|------|---------------------|------------------|----------|------------------|---|------------------|
| <b>VACCINATION AGAINST SMALLPOX</b> (Number of previous vaccination scars) |      |                     |                  |          |                  |   |                  |
|  | DATE | ORIGIN              | BATCH NUMBER     | REACTION | STATION          | PHYSICIAN'S NAME                                      |                  |
| 1  |      |                     |                  |          |                  |   |                  |
| 2  |      |                     |                  |          |                  |   |                  |
| 3  |      |                     |                  |          |                  |   |                  |
| 4  |      |                     |                  |          |                  |   |                  |
| 5  |      |                     |                  |          |                  |   |                  |
| 6  |      |                     |                  |          |                  |   |                  |
| <b>YELLOW FEVER VACCINE</b>  |      |                     |                  |          |                  |   |                  |
|  | DATE | ORIGIN              | BATCH NUMBER     | STATION  |                  | PHYSICIAN'S NAME                                      |                  |
| 1  |      |                     |                  |          |                  |   |                  |
| 2  |      |                     |                  |          |                  |   |                  |
| 3  |      |                     |                  |          |                  |   |                  |
| <b>TYPHOID VACCINE</b>   |      |                     |                  |          |                  |   |                  |
|  | DATE | DOSE                | PHYSICIAN'S NAME |          | DATE             | DOSE  | PHYSICIAN'S NAME |
| 1  |      |                     |                  | 4        |                  |   |                  |
| 2  |      |                     |                  | 5        |                  |   |                  |
| 3  |      |                     |                  | 6        |                  |   |                  |
| <b>TETANUS-DIPHTHERIA TOXOIDS</b>  |      |                     |                  |          |                  |   |                  |
|  | DATE | DOSE                | PHYSICIAN'S NAME |          | DATE             | DOSE  | PHYSICIAN'S NAME |
| 1  |      |                     |                  | 4        |                  |   |                  |
| 2  |      |                     |                  | 5        |                  |   |                  |
| 3  |      |                     |                  | 6        |                  |   |                  |
| <b>CHOLERA VACCINE</b>   |      |                     |                  |          |                  |   |                  |
|  | DATE | PHYSICIAN'S NAME    |                  | DATE     | PHYSICIAN'S NAME |   | DATE             |
| 1  |      |                     | 4                |          |                  | 7   |                  |
| 2  |      |                     | 5                |          |                  | 8   |                  |
| 3  |      |                     | 6                |          |                  | 9   |                  |

**PATIENTS IDENTIFICATION** (Mechanically Imprint, Type or Print):

- ▶ Patient's Name – last, first, middle initial;  
Sex; age or Year Of Birth; Relationship to Sponsor;  
Component/Status; Department/Service.
- ▶ Sponsor's Name – last, first, middle initial;  
Rank/Grade; SSN or Identification Number;  
Organization.

IMMUNIZATION RECORD  
Standard Form 601 – October 1975 (Rev.)  
General Services Administration & Interagency  
Committee on Medical Records  
FIRMR (41 CFR) 201-45.505



**FIGURE 4-B-15 (Reverse)**

| ORAL POLIOVIRUS VACCINE |      |      |                  |   |      |      |                  |
|-------------------------|------|------|------------------|---|------|------|------------------|
|                         | DATE | DOSE | PHYSICIAN'S NAME |   | DATE | DOSE | PHYSICIAN'S NAME |
| 1                       |      |      |                  | 3 |      |      |                  |
| 2                       |      |      |                  | 4 |      |      |                  |

| INFLUENZA VACCINE |      |      |                  |   |      |      |                  |
|-------------------|------|------|------------------|---|------|------|------------------|
|                   | DATE | DOSE | PHYSICIAN'S NAME |   | DATE | DOSE | PHYSICIAN'S NAME |
| 1                 |      |      |                  | 3 |      |      |                  |
| 2                 |      |      |                  | 4 |      |      |                  |

| INFLUENZA VACCINE |      |      |      |                  |   |      |      |      |                  |
|-------------------|------|------|------|------------------|---|------|------|------|------------------|
|                   | DATE | TYPE | DOSE | PHYSICIAN'S NAME |   | DATE | TYPE | DOSE | PHYSICIAN'S NAME |
| 1                 |      |      |      |                  |   |      |      |      |                  |
| 2                 |      |      |      |                  |   |      |      |      |                  |
| 3                 |      |      |      |                  | 7 |      |      |      |                  |
| 4                 |      |      |      |                  | 8 |      |      |      |                  |

| SENSITIVITIES TEST <i>(Tuberculin, etc.)</i> |      |      |      |       |         |                  |
|--|------|------|------|-------|---------|------------------|
|  | DATE | TYPE | DOSE | ROUTE | RESULTS | PHYSICIAN'S NAME |
| 1  |      |      |      |       |         |                  |
| 2  |      |      |      |       |         |                  |
| 3  |      |      |      |       |         |                  |
| 4  |      |      |      |       |         |                  |
| 5  |      |      |      |       |         |                  |

**REMARKS:**

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO 2.



**FIGURE 4-B-16**

| HEALTH RECORD   |  |                                     |            | SYPHILIS RECORD  |  |       |
|---|--|-------------------------------------|------------|--|--|-------|
| SECTION 1. – HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS  |  |                                     |            |  |  |       |
| DATE  | DISEASE<br><small>(Give stage)</small> | PRIOR TO MIL. SERVICE               |            | TREATMENT<br><small>(Give type, amount and dates)</small>  | TREATING AGENCY                          | PLACE |
|   |  | YES                                 | NO         |  |  |       |
| 1   |  |                                     |            |  |  |       |
| 2   |  |                                     |            |  |  |       |
| 3   |  |                                     |            |  |  |       |
| 4   |  |                                     |            |  |  |       |
| SECTION II = HISTORY OF PRESENT INFECTION   |  |                                     |            |  |  |       |
| CAME TO MEDIAL ATTENTION BY:      VOLUNTARY <input type="checkbox"/> CONTACT REPORT <input type="checkbox"/> PHYSICAL INSPECTION <input type="checkbox"/> FOOD HANDLER <input type="checkbox"/>   |  |                                     |            |  |  |       |
| INCIDENT TO HOSPITALIZATION   |  | PREMARITAL <input type="checkbox"/> |            | PRENATAL <input type="checkbox"/>                          | OTHER (Specify) <input type="checkbox"/> |       |
| DATES: ONSET SYMPTOMS   |  |                                     |            | REQUESTED TREATMENT  | DIAGNOSIS ESTABLISHED                    |       |
| DIAGNOSIS <small>(Include stage and diagnosis No.)</small>  |  |                                     |            | DIAGNOSTIC CRITERIA <small>(Enter results of test)</small> |  |       |
|   |  |                                     |            |  |  |       |
| LIST VD CONTACT FORM SERIAL NOS.  |  |                                     |            |  |  |       |
| <div style="font-size: 4em; color: blue; opacity: 0.5; transform: rotate(-15deg); pointer-events: none;">SAMPLE FORM</div>  |  |                                     |            |  |  |       |
| RECOMMENDED TREATMENT AND FOLLOW-UP   |  |                                     |            | SIGNATURE OF PHYSICIAN                                     |  | DATE  |
| HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYPHILIS AS INDICATED ABOVE; THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME; I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION <small>(including certain prescribed tests)</small> FOR THE CARE OF THIS DISEASE. |  |                                     |            | SIGNATURE OF PATIENT AND DATE                              |  |       |
|   |  |                                     |            |  |  |       |
| SECTION III. - TREATMENT  |  |                                     |            |  |  |       |
|   | TREATMENT                              | DATE STARTED                        | DATE ENDED | SIGNATURE OF PHYSICIAN                                     |  |       |
| 1   |  |                                     |            |  |  |       |
| 2   |  |                                     |            |  |  |       |
| 3   |  |                                     |            |  |  |       |
| 4   |  |                                     |            |  |  |       |

**PATIENT'S IDENTIFICATION** (Mechanically Imprint, Type or Print):



Patient's Name – last, first, middle initial;  
 Sex; age or Year Of Birth; Relationship to Sponsor;  
 Component/Status; Department/Service.  
  
 Sponsor's Name – last, first, middle initial;  
 Rank/Grade; SSN or Identification Number;  
 Organization.

**SYPHILIS RECORD**  
 Standard Form 602 – March – 1975 (Rev.)  
 General Services Administration &  
 Interagency Comm on Medical Records



**FIGURE 4-B-16 (Reverse)**

| SECTION IV. – CUMULATIVE LABORATORY SUMMARY  |      |                          |                              |                                    |   |                       |      |                              |            |
|--|------|--------------------------|------------------------------|------------------------------------|---|-----------------------|------|------------------------------|------------|
| <b>RESULTS OF DARKFIELD EXAMINATION</b>  |      |                          |                              |                                    |   |                       |      |                              |            |
|  | DATE | RESULTS                  | SOURCE OF SPECIMEN           | LABORATORY                         | NAME OF CONFIRMING OFFICER                          |                       |      |                              |            |
| 1  |      |                          |                              |                                    |   |                       |      |                              |            |
| 2  |      |                          |                              |                                    |   |                       |      |                              |            |
| <b>RESULTS OF SEROLOGICAL TESTS FOR SYPHILIS</b>   |      |                          |                              |                                    |   |                       |      |                              |            |
|  | DATE | TYPE                     | RESULT (Include titer value) | LABORATORY                         |   | DATE                  | TYPE | RESULT (Include Titer value) | LABORATORY |
| 1  |      |                          |                              |                                    | 5   |                       |      |                              |            |
| 2  |      |                          |                              |                                    | 6   |                       |      |                              |            |
| 3  |      |                          |                              |                                    | 7   |                       |      |                              |            |
| 4  |      |                          |                              |                                    | 8   |                       |      |                              |            |
| <b>FLUORESCENT ANTIBODY TESTS</b>  |      |                          |                              |                                    |   |                       |      |                              |            |
|  | DATE |                          |                              |                                    |   |                       |      |                              |            |
| 1  |      |                          |                              |                                    |   |                       |      |                              |            |
| 2  |      |                          |                              |                                    |   |                       |      |                              |            |
| <b>RESULTS OF SPINAL FLUID EXAMINATION</b>   |      |                          |                              |                                    |   |                       |      |                              |            |
|  | DATE | CELLS                    | TOTAL PROTEIN                | SEROLOGICAL TEST (Including titer) |   |                       |      | LABORATORY WHERE DONE        |            |
| 1  |      |                          |                              |                                    |   |                       |      |                              |            |
| 2  |      |                          |                              |                                    |   |                       |      |                              |            |
| <b>SECTION V. – EVALUATION OF THERAPY</b>  |      |                          |                              |                                    |   |                       |      |                              |            |
|  | DATE | FACILITY WHERE EVALUATED | RESULT                       |                                    | DATE OF RETREATMENT                                 | PHYSICIAN'S SIGNATURE |      |                              |            |
|  |      |                          | Satisfactory                 | UNSATISFACTORY                     |   |                       |      |                              |            |
| 1  |      |                          |                              |                                    |   |                       |      |                              |            |
| 2  |      |                          |                              |                                    |   |                       |      |                              |            |
| 3  |      |                          |                              |                                    |   |                       |      |                              |            |
| 4  |      |                          |                              |                                    |   |                       |      |                              |            |
| *Satisfactory result cannot be reported without normal spinal fluid findings.                                |      |                          |                              |                                    |   |                       |      |                              |            |
| **Specify: Infectious Relapse: Sero-Relapse, Neuro-Relapse, Incomplete data on Spinal Fluid, Other (Specify) |      |                          |                              |                                    |   |                       |      |                              |            |
| REASON FOR INADEQUATE FOLLOW-UP (Date, place and type of separation – Give authority for discharge)          |      |                          |                              |                                    |   |                       |      |                              |            |
| PATIENT'S HOME ADDRESS ON SEPARATION   |      |                          |                              |                                    | CIVILIAN HEALTH DEPT. TO WHICH CASE RESUME WAS SENT |                       |      |                              |            |
| REINFECTION (Give date new record was opened)  |      |                          |                              |                                    |   |                       |      |                              |            |
| REMARKS  |      |                          |                              |                                    |   |                       |      |                              |            |
| <b>SECTION VI. – MEDICAL OFFICER CLOSING THIS RECORD</b>   |      |                          |                              |                                    |   |                       |      |                              |            |
| NAME (Typed or printed)  |      |                          | SIGNATURE                    |                                    | STATION   |                       | DATE |                              |            |
| <b>SECTION VII. – MEDICAL OFFICER SENDING ABSTRACT TO VETERAN'S ADMINISTRATION ON DISCHARGE</b>              |      |                          |                              |                                    |   |                       |      |                              |            |
| NAME (Typed or printed)  |      |                          | SIGNATURE                    |                                    | STATION   |                       | DATE |                              |            |



**FIGURE 4-B-17**

| RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION |   |                   |   |                        |         |                   |                  |                      |                      |
|---|---|-------------------|---|------------------------|---------|-------------------|------------------|----------------------|----------------------|
| <i>For instructions See Reverse of Sheet</i>          |   |                   |   |                        |         |                   |                  |                      |                      |
| Identification Number                                 | Name ( <i>Last, First, Middle Initial</i> ) |                   |   | Social Security Number |         | Rank/Rate/Title   |                  | Date of Birth        |                      |
| Place Where Exposure Occurred                         | Period of Exposure                          |                   | Dose This Period<br>1. Method of monitoring is presumed to be film badge reading unless otherwise specified under item 16, "REMARKS." |                        |         |                   | Accumulated Dose |                      | Initial              |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
| Activity  | From<br>(Day-Mo-Yr)                         | To<br>(Day-Mo-Yr) | Skin Dose<br>(Salt)   | Gamma and X-Ray        | Neutron | Total This Period | Total Life Time  | Permissible Lifetime | Persons Making Entry |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |
|   |   |                   |   |                        |         |                   |                  |                      |                      |

SAMPLE FORM

16. Remarks:

**TO BE RETAINED PERMANENTLY IN INDIVIDUAL'S MEDICAL RECORD**



**FIGURE 4-B-18**

| Department of Transportation<br>U.S. Coast Guard<br>CG-4057 (Rev 2-01) | <b>CHRONOLOGICAL RECORD OF SERVICE</b> |               |
|--|--|---------------|
| DATE ATTACHED  | UNIT OR STATION                        | DATE DETACHED |
|  |  |               |
|  |  |               |
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|  |  |               |
|  |  |               |
| Name (Last, First, Middle)   | Social Security Number                 |               |

SAMPLE FORM



**FIGURE 4-B-18 (Reversed)**

Page 2 of 2 CG-4057 (Rev 2-01)

| <b>AGREEMENT/DISAGREEMENT</b>   |            |                     |
|---|------------|---------------------|
| I agree <input type="checkbox"/> (or) do not agree <input type="checkbox"/> that at the time of separation:   |            |                     |
| (2) I am reasonably able to perform my current duties, or   |            |                     |
| (2) I have a high expectation of recovery in the near term from illness, injury or surgical procedure such that I would again be able to perform my usual duties.   |            |                     |
| Date  | Grade/Rate | Signature of Member |
| <b>TERMINATION OF HEALTH RECORD</b>   |            |                     |
| Remarks   |            |                     |
| <p>Impairments, which have been documented in your health record, including any separation exam, while establishing service connection, do not in themselves indicate a disability. To receive disability benefits from the Coast Guard, you must be found unfit to perform your assigned duties through the physical disability evaluation system before you are separated.</p> <p>After you are separated, any claims for disability benefits must be submitted to the Department of Veterans Affairs. If you have questions about certain benefits to which you might be entitled you should contact the DVA Regional Office nearest your home as soon as practical.</p> <p>I have read the above statements and acknowledge receipt of a copy of the following:</p> <ol style="list-style-type: none"><li>1. CG-4057, Chronological record of Service.</li><li>2. SF-88 report of Medical Examination date_____ (if performed).</li><li>3. PHS-731, International Certificate of Vaccination.</li><li>4. DD Form 2766, Adult Preventive and Chronic Care Flowsheet.</li></ol> |            |                     |
| Date  | Grade/Rate | Signature of Member |
| <b>COMMAND CERTIFICATION</b>  |            |                     |
| <p>Health record terminated this date by reason of_____</p> <p>In accordance with Chapter 4, Medical Manual, COMDTINST M6000.1 (series)</p>   |            |                     |
| Date  | Title      | Signature           |



**FIGURE 4-B-19**

|   |                   |                       |  |                              |                   |
|---|-------------------|-----------------------|--|------------------------------|-------------------|
| NAVMED – 6150/2 (REV 8-70)                              |                   |                       | <b>SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)</b> |                              |                   |
| <b>Health Record</b>                                    |                   |                       | <b>Special Duty Medical Abstract</b>                 |                              |                   |
| <b>Summary of Physical Examination for Special Duty</b> |                   |                       |  |                              |                   |
| Date  | Place             | Purpose               | Result – Recommendation ( <i>Defects Reverse</i> )   | BUMED Action                 | Sig. Of M.D.      |
| 1.  |                   |                       |  |                              |                   |
| 2.  |                   |                       |  |                              |                   |
| 3.  |                   |                       |  |                              |                   |
| 4.  |                   |                       |  |                              |                   |
| 5.  |                   |                       |  |                              |                   |
| 6.  |                   |                       |  |                              |                   |
| 7.  |                   |                       |  |                              |                   |
| 8.  |                   |                       |  |                              |                   |
| 9.  |                   |                       |  |                              |                   |
| <b>Suspension From Special Duty</b>                     |                   |                       |  |                              |                   |
| Date ( <i>From</i> ) ( <i>To</i> )                      | No. of Days       | Reason for Suspension |  | Signature of Medical Officer |                   |
| 1.  |                   |                       |  |                              |                   |
| 2.  |                   |                       |  |                              |                   |
| 3.  |                   |                       |  |                              |                   |
| 4.  |                   |                       |  |                              |                   |
| 5.  |                   |                       |  |                              |                   |
| 6.  |                   |                       |  |                              |                   |
| 7.  |                   |                       |  |                              |                   |
| <b>Periodic Special Duty Requalification</b>            |                   |                       |  |                              |                   |
| Date  | Signature of . O. | Date                  | Signature of M.O.                                    | Date                         | Signature of M.O. |
|   |                   |                       |  |                              |                   |
|   |                   |                       |  |                              |                   |
|   |                   |                       |  |                              |                   |
|   |                   |                       |  |                              |                   |
|   |                   |                       |  |                              |                   |
|   |                   |                       |  |                              |                   |
|   |                   |                       |  |                              |                   |
| Name (Last) (First) (Middle)                            |                   | Grade/Rate            |  | Service/Soc. Sec.            | Organization      |



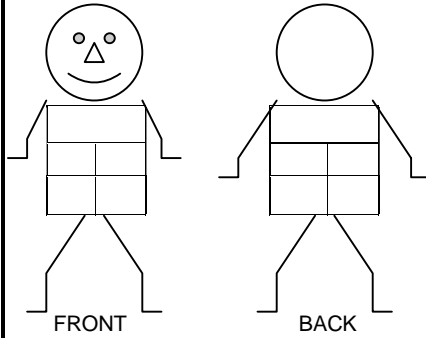
**FIGURE 4-B-19 (Reverse)**

| <b>SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)</b>           |         |                        |                   |
|--|---------|------------------------|-------------------|
| <b>Altitude Training, Air Compression and Oxygen Tolerance</b> |         |                        |                   |
| Date   | Station | Type of Run – Reaction | Signature or M.O. |
| 1.   |         |                        |                   |
| 2.   |         |                        |                   |
| 3.   |         |                        |                   |
| 4.   |         |                        |                   |
| 5.   |         |                        |                   |
| <b>Explosive Decompression Training</b>                        |         |                        |                   |
| Date   | Station | Altitudes - Reaction   | Signature or M.O. |
| 1.   |         |                        |                   |
| 2.   |         |                        |                   |
| <b>Submarine Escape and Diving Training</b>                    |         |                        |                   |
| Date   | Station | Type of Run - Reaction | Signature or M.O. |
| 1.   |         |                        |                   |
| 2.   |         |                        |                   |
| 3.   |         |                        |                   |
| 4.   |         |                        |                   |
| 5.   |         |                        |                   |
| <b>Visual and Disorientation Training</b>                      |         |                        |                   |
| Date   | Station | Type of Training       | Signature or M.O. |
| 1.   |         |                        |                   |
| 2.   |         |                        |                   |
| 3.   |         |                        |                   |
| 4.   |         |                        |                   |
| <b>Centrifuge and Ejection Seat Training</b>                   |         |                        |                   |
| Date   | Station | Type of run – Reaction | Signature or M.O. |
| 1.   |         |                        |                   |
| 2.   |         |                        |                   |
| Remarks  |         |                        |                   |



**FIGURE 4-B-20**

**EMERGENCY MEDICAL TREATMENT REPORT**

| <b>VICTIM IDENTIFICATION</b>   | 1. Name _____<br>2. Sex (check one)    male _____<br>female _____<br>3. Estimated age    yrs _____ mos _____  | <b>RESCUER INFORMATION</b> | 10. Name: _____ 11. Level: _____<br>12. Unit: _____<br>13. OPFAC #: _____<br>14. Rescue Vehicle: _____<br>15. Receiving Unit: _____<br>16. Time Patient Transferred: _____ |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
|--|---|----------------------------|--|--|-------------------|--------------------|---------------------|--|-----------------|--------------------------|--------|-----|------------------|--|--|--|--|--------------------|--|--|--|--|----------|--|--|--|--|
| <b>DESCRIPTION OF INCIDENT</b>   | 4. Date: _____ 5. Type of incident: _____<br>6. Time on Scene: _____ a) marine _____<br>7. Time of incident: _____ b) aviation _____<br>c) Industrial _____<br>8. Location: _____ d) auto _____<br>e) domestic _____<br>f) other _____  |                            | <b>NATURE OF EMERGENCY / MECHANISM OF INJURY</b>   |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>OBSERVATION OF VISTIM</b>   | <div style="display: flex; justify-content: space-around; align-items: center;">  <div style="margin-left: 20px;"> <b>TREATMENT</b><br/>           (CIRCLE AS NEEDED)<br/>           - DRESSING<br/>           2 - TX SPLINT<br/>           3 - SPLINT<br/>           4 - C/COLLAR<br/>           5 - BACK BOARD<br/>           6 - TOURNIQUET<br/>           7 - CPR<br/>           8 - AIRWAY<br/>           9 - OXYGEN<br/>           10 - MAST<br/>           11 - MILLER B/B         </div> </div> <div style="margin-top: 10px;"> <b>MEDICATIONS:</b><br/><br/> <b>ALLERGIES</b><br/><br/> <b>MEDICAL HISTORY / COMMENTS /ETC.</b><br/>           (include additional vitals, oxygen, fluids, etc.)         </div> |                            | SAMPLE FORM  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>SKIN</b>  | (Circle appropriate number of numbers)<br>1 - normal                      4 - cyanotic                      7 - cool<br>2 - pale/ashen                5 - dry                              8 - warm<br>3 - flushed                    6 - moist                         9 - hot   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>VITAL SIGNS</b>   | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;">TIME</th> <th style="width:15%;"></th> <th style="width:15%;"></th> <th style="width:15%;"></th> <th style="width:15%;"></th> </tr> <tr> <td><b>OBSERVED</b></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>  |                            |  | TIME                                   |                   |                    |                     |  | <b>OBSERVED</b> |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| TIME   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>OBSERVED</b>  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>LEVEL OF CONSCIOUS</b>  | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Alert</td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td>Responds to Verbal</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Responds to Pain</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Uncon/Unresponsive</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>  |                            | Alert  |  |                   |                    |                     | Responds to Verbal   |                 |                          |        |     | Responds to Pain |  |  |  |  | Uncon/Unresponsive |  |  |  |  |          |  |  |  |  |
| Alert  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Responds to Verbal   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Responds to Pain   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Uncon/Unresponsive   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>PUPILS</b>  | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Peri</td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td>Unequal</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Nonreactive</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Dilated</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pinpoint</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>   |                            | Peri   |  |                   |                    |                     | Unequal  |                 |                          |        |     | Nonreactive      |  |  |  |  | Dilated            |  |  |  |  | Pinpoint |  |  |  |  |
| Peri   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Unequal  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Nonreactive  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Dilated  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Pinpoint   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>PULSE</b>   | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Rate (Numeric)</td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td>Strong</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Weak</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rate (Numeric)</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>   |                            | Rate (Numeric)   |  |                   |                    |                     | Strong   |                 |                          |        |     | Weak             |  |  |  |  | Rate (Numeric)     |  |  |  |  |          |  |  |  |  |
| Rate (Numeric)   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Strong   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Weak   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Rate (Numeric)   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>BREATHING</b>   | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Regular</td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td>Shallow</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Labored</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>   |                            | Regular  |  |                   |                    |                     | Shallow  |                 |                          |        |     | Labored          |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Regular  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Shallow  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Labored  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>BLOOD PRESSURE</b>  | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Blood Pressure</td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> </table>  |                            | Blood Pressure   |  |                   |                    |                     | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;">TIME</th> <th style="width:45%;">MEDICATIONS ADMINISTERED</th> <th style="width:40%;">DOSAGE</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> | TIME            | MEDICATIONS ADMINISTERED | DOSAGE |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Blood Pressure   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| TIME   | MEDICATIONS ADMINISTERED  | DOSAGE                     |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
|  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
|  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
|  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>TEMP</b>  | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">Temperature ORAL</td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td>(circle) RECTAL</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>  |                            | Temperature ORAL   |  |                   |                    |                     | (circle) RECTAL  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| Temperature ORAL   |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| (circle) RECTAL  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>MAST</b>  | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">MAST BP</td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td>COMPARTMENT</td> <td></td> <td>R</td> <td>L</td> <td>ABD</td> </tr> </table>  |                            | MAST BP  |  |                   |                    |                     | COMPARTMENT  |                 | R                        | L      | ABD |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| MAST BP  |   |                            |  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| COMPARTMENT  |   | R                          | L  | ABD                                    |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:35%;"> <b>TRIAGE INFORMATION</b>    (CIRCLE ONE)         </td> <td style="width:15%;"> <b>PRIORITY I</b> </td> <td style="width:15%;"> <b>PRIORITY II</b> </td> <td style="width:35%;"> <b>PRIORITY III</b> </td> </tr> </table> |   |                            |  | <b>TRIAGE INFORMATION</b> (CIRCLE ONE) | <b>PRIORITY I</b> | <b>PRIORITY II</b> | <b>PRIORITY III</b> |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |
| <b>TRIAGE INFORMATION</b> (CIRCLE ONE)   | <b>PRIORITY I</b>   | <b>PRIORITY II</b>         | <b>PRIORITY III</b>  |  |                   |                    |                     |  |                 |                          |        |     |                  |  |  |  |  |                    |  |  |  |  |          |  |  |  |  |

DEPT. OF TRANSPORTATION., USCG CG-5214 (Rev. 10-88)

PATIENT COPY

Previous Edition May be Used



|   |  |   |  |                        |  |
|---|--|---|--|------------------------|--|
| <b>REQUEST FOR MEDICAL/DENTAL RECORD OR INFORMATION</b>   |  | <b>REQUESTING ACTIVITY</b> Complete Items 1 through 10 (Except 8b); also Complete Item 19.        |  | <b>Date</b>            |  |
| <b>ADDRESSEE</b> — Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, Final referrer shall return to requester. |  |   |  |                        |  |
| 1. PATIENT (Last Name — First Name — Middle Name)   |  | 3. STATUS <input type="checkbox"/> MILITARY <input type="checkbox"/> VA BENEFICIARY               |  |                        |  |
| 2. ORGANIZATION AND PLACE OF TREATMENT  |  | <input type="checkbox"/> DEPENDENT <input type="checkbox"/> FEDERAL EMPLOYEE                      |  |                        |  |
|   |  | <input type="checkbox"/> OTHER (Specify)  |  |                        |  |
|   |  | 3a. NAME OF SPONSOR (If dependent)  |  |                        |  |
| 4. TO (Include ZIP Code)  |  | 5. IDENTIFYING INFORMATION  |  |                        |  |
| <div><div></div><div></div></div>   |  | a. SERVICE NUMBER   |  |                        |  |
|   |  | b. GRADE/RATE   |  |                        |  |
|   |  | c. SOCIAL SECURITY ACCOUNT NO.  |  |                        |  |
|   |  | d. VA CLAIM NUMBER  |  |                        |  |
|   |  | e. DATE OF BIRTH (If federal employee)  |  |                        |  |
| 6. DATES OF TREATMENT   |  | 7. DISEASE OR INJURY  |  |                        |  |
| 8. a. RECORDS REQUESTED MIL VA  |  | b. RECORDS FORWARDED MIL VA   |  | 9. REMARKS             |  |
| <input type="checkbox"/> <input type="checkbox"/> CLINICAL  |  | <input type="checkbox"/> <input type="checkbox"/>   |  | <div>SAMPLE FORM</div> |  |
| <input type="checkbox"/> <input type="checkbox"/> OUTPATIENT  |  | <input type="checkbox"/> <input type="checkbox"/>   |  |                        |  |
| <input type="checkbox"/> HEALTH RECORD  |  | <input type="checkbox"/> <input type="checkbox"/>   |  |                        |  |
| <input type="checkbox"/> <input type="checkbox"/> DENTAL RECORD   |  | <input type="checkbox"/> <input type="checkbox"/>   |  |                        |  |
| <input type="checkbox"/> <input type="checkbox"/> X-RAY   |  | <input type="checkbox"/> <input type="checkbox"/>   |  |                        |  |
| <input type="checkbox"/> MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS                            |  | <input type="checkbox"/>  |  |                        |  |
| <input type="checkbox"/> ABSTRACT OF RATING SHEET   |  | <input type="checkbox"/>  |  |                        |  |
| <input type="checkbox"/> <input type="checkbox"/> REPORT OF PHYSICAL EXAMINATION                                      |  | <input type="checkbox"/> <input type="checkbox"/>   |  |                        |  |
| <input type="checkbox"/> ALL AVAILABLE RECORDS (Except X-rays unless specifically requested)                          |  | <input type="checkbox"/>  |  | 10. SIGNATURE          |  |
| <input type="checkbox"/> <input type="checkbox"/> OTHERS (List under remarks)   |  | <input type="checkbox"/> <input type="checkbox"/>   |  |                        |  |
| REPLY/REFERRAL  |  |   |  |                        |  |
| 11. TO:   |  | 12. REMARKS   |  |                        |  |
| 13. SIGNATURE   |  | 14. DATE  |  |                        |  |
|   |  | 12. REMARKS   |  |                        |  |
| REPLY/SECOND REFERRAL   |  |   |  |                        |  |
| 15. TO:   |  | 16. REMARKS   |  |                        |  |
| 17. SIGNATURE   |  | 18. DATE  |  |                        |  |
|   |  | 16. REMARKS   |  |                        |  |
| 19. RETURN TO: (Include ZIP Code)   |  | REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED. |  |                        |  |



## Section C - Dental Record Forms.

### 1. CG-3443-2 (Dental Record Cover)

- a. Open a CG-3443-2 for each individual upon arrival at a training center or initial entry into the Coast Guard or Coast Guard Reserve. When an individual on the retired list returns to active duty, submit a request for a copy of the closed out dental record to Commandant (G-PIM). Whenever the original record is lost or destroyed, a new dental record shall be opened immediately. Normally the dental record shall be kept in the Health Record Cover (CG-3443) of each individual unless otherwise specified.
- b. All dental forms and radiographs will be contained in the Dental Record.
- c. Detailed Instructions.

- (1) Surname. Record the surname in all capital letters.

**DOE**

**SURNAME**

- (2) Given name(s). Record in full without abbreviation. If the individual has no middle name or initial then record the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are used, they shall appear after the middle name or initial.

**DOE      JANE      ANN**

**SURNAME   First Name   Middle Name**

- (3) Social Security Number (SSN). Enter Social Security Number.
- (4) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.), and the year: i.e., 4 SEP 49.
- (5) Change in Grade or Rate. Enter as they occur.
- (6) Blood Type. Enter the individual's blood type in the appropriate box. If not known, perform a blood type test.
- (7) RH Factor. Enter the individual's RH factor in the appropriate box. If not known, perform an RH factor test.
- (8) Drug Sensitivity Sticker. When required, affix the Drug Sensitivity Sticker (CG-5266) to the lower left corner of the front of the Dental Record Cover. Do not cover other identification data. See FIGURE 4-C-1.
- (9) Dental Radiographs.



- (a) **Dental Bitewing Radiograph Storage.** Bitewing radiographs shall be stored in the standard stock 5 year x-ray card (FSC# 6525-00-142-8732). This shall replace the single bitewing x-ray card (FSC# 6525-00-817-2364). X-ray film is mounted in the x-ray card with the raised dot side of the film on the back side of the card.

2. NAVMED 6600/3 (Dental Health Questionnaire)

- a. General. CG-5605 will help the dental officer detect any present or past health problem (i.e., positive Human Immunodeficiency Virus (HIV)) that might interfere with definitive dental treatment. All positive answers from the health history section must be followed up by the dental officer for impact on health care and so annotated on the CG-5605 and/or the SF-603A.
- b. Detailed Instructions. Insert the Dental Health Questionnaire as the first page of the dental record. Patients shall fill out a new Dental Health Questionnaire at least annually, or when information changes. Maintain the two most recent forms in the dental record with the current CG-5605 on top. See FIGURE 4-C-2.
  - (1) **Chief Complaint.** Have the patient enter the problem they are presently having.
  - (2) **Check and Sign.** Have the patient enter yes/no in each box of the history. The signature indicates the authenticity of the history.
  - (3) **Summary of Pertinent Findings.** Include baseline BP reading.

3. SF-603 (Dental Record). (See FIGURE 4-C-3)

- a. General. The Dental Record is a continuous history and must contain accurate and complete entries of dental examinations and treatments. Each entry shall clearly indicate the name of the dental officer conducting the examination and/or rendering the treatment. Dental hygienists or other auxiliary personnel providing care shall also follow this requirement. Each dental officer is personally responsible for ensuring that all entries are properly recorded.
- b. Numerical Classification for Record Purposes. Chart markings have been standardized so that dental conditions, treatments needed, and treatments completed may be readily identified. This facilitates efficient continuity of treatments and may establish identification in certain circumstances.
  - (1) For the purpose of brevity and exactness, use the following classification of teeth in keeping the dental record.

**TOOTH**

**DESIGNATION**

|                              |   |
|------------------------------|---|
| Right Maxillary Third Molar  | 1 |
| Right Maxillary Second Molar | 2 |



|                                  |    |
|----------------------------------|----|
| Right Maxillary First Molar      | 3  |
| Right Maxillary Second Bicuspid  | 4  |
| Right Maxillary First Bicuspid   | 5  |
| Right Maxillary Cuspid           | 6  |
| Right Maxillary Lateral Incisor  | 7  |
| Right Maxillary Central Incisor  | 8  |
| Left Maxillary Central Incisor   | 9  |
| Left Maxillary Lateral Incisor   | 10 |
| Left Maxillary Cuspid            | 11 |
| Left Maxillary First Bicuspid    | 12 |
| Left Maxillary Second Bicuspid   | 13 |
| Left Maxillary First Molar       | 14 |
| Left Maxillary Second Molar      | 15 |
| Left Maxillary Third Molar       | 16 |
| Left Mandibular Third Molar      | 17 |
| Left Mandibular Second Molar.    | 18 |
| Left Mandibular First Molar      | 19 |
| Left Mandibular Second Bicuspid  | 20 |
| Left Mandibular First Bicuspid   | 21 |
| Left Mandibular Cuspid           | 22 |
| Left Mandibular Lateral Incisor  | 23 |
| Left Mandibular Central Incisor  | 24 |
| Right Mandibular Central Incisor | 25 |
| Right Mandibular Lateral Incisor | 26 |
| Right Mandibular Cuspid          | 27 |
| Right Mandibular First Bicuspid  | 28 |
| Right Mandibular Second Bicuspid | 29 |
| Right Mandibular First Molar     | 30 |
| Right Mandibular Second Molar    | 31 |
| Right Mandibular Third Molar     | 32 |

- (2) Indicate deciduous teeth by placing a block "D" around tooth number. If both permanent and deciduous teeth are present, place a "D" in location of deciduous tooth and enter the appropriate tooth number inside the "D."



- (3) Indicate a supernumerary tooth by placing "s" in the location of the supernumerary tooth and in the remarks section enter a statement that the examinee has a supernumerary tooth.
- (4) Indicate deciduous and supernumerary teeth on the SF-603 in SECTION I, Part 5 (Diseases, Abnormalities, and Radiographs) and enter a statement in the remarks section of Section 5.

c. Detailed Instructions.

**SECTION I. DENTAL EXAMINATION**

- (1) Purpose of Examination. To assess the oral health status of cadets, officer candidates and enlisted recruits upon initial entry into the Coast Guard, and to provide periodic (but at least annual) examinations of active duty personnel. Enter an "X" in the appropriate box. Mark the "Initial" box for the dental examination made upon entrance into the Coast Guard. All other examinations fall under the "Other" category and shall be identified: i.e., "Academy", "Reenlistment", etc.
- (2) Type of Examination. Enter an "X" in the proper box of item 2, "Type of Exam."
  - (a) Type 1, Comprehensive Examination. Comprehensive hard and soft tissue examination, which shall include: oral cancer screening examination; mouth-mirror, explorer, and periodontal probe examination; adequate natural or artificial illumination; panographic or full-mouth periapical, and posterior bitewing radiographs as required; blood pressure recording; and when indicated, percussive, thermal, and electrical tests, transillumination, and study models. Included are lengthy clinical evaluations required to establish a complex total treatment plan. For example, treatment planning for full mouth reconstruction, determining differential diagnosis of a patient's chief complaint, or lengthy history taking relative to determining a diagnosis. Use S.O.A.P. format to record the results of a Type 1 examination.
  - (b) Type 2, Oral Examination (annual or periodic). Hard and soft tissue examination, which shall include: oral cancer screening examination; mouth mirror and explorer examination with adequate natural or artificial illumination; periodontal screening; appropriate panographic or intraoral radiographs as indicated by the clinical examination; and blood pressure recording. An appropriate treatment plan shall be recorded. This type is the routine examination which is normally performed one time per treatment regimen per patient, unless circumstances warrant another complete examination. Use S.O.A.P. format to record the results of Type 2 examination.



- (c) Type 3, Other Examination. Diagnostic procedure as appropriate for: consultations between staff; observation where no formal consult is prepared; certain categories of physical examination; and emergency oral examination for evaluation of pain, infection, trauma, or defective restorations.
  - (d) Type 4, Screening Evaluation. Mouth mirror and explorer or tongue depressor examination with available illumination. This includes the initial dental processing of candidates without necessarily being examined by a dentist, or other dental screening procedures.
  - (e) If not specified by this Manual, it shall be the professional responsibility of the dental officer to determine the type of examination which is appropriate for each patient. However, Type 3 and Type 4 examinations are not adequate to definitively evaluate the oral health status of patients. When the dental officer determines that a comprehensive periodontal examination is to be accomplished, use the Navy Periodontal Chart, NAVMED 6660/2 (3-90).
- (3) Dental Classification of Individuals. Dental classifications are used to designate the health status and the urgency or priority of treatment needs for active duty personnel. Use the following guidelines and criteria for the classification of patients. When a criterion for a specific condition is not listed, the dental officer shall evaluate the prognosis for a dental emergency and assign the appropriate classification.
- (a) Class 1. Patients who do not require dental treatment. The following are criteria for such classification.
    - 1 no dental caries or defective restorations;
    - 2 healthy periodontium, no tooth accumulated materials (hard or visible soft deposits);
    - 3 stable occlusion, asymptomatic temporomandibular joint;
    - 4 unerupted or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, and are not recommended for prophylactic removal; and
    - 5 no edentulous spaces for which a prosthesis is indicated.
  - (b) Class 2. Patients who have dental conditions that are unlikely to result in a dental emergency within 12 months. Class 2 dental patients are considered fit for operational duties, but the dental diseases or conditions causing designation shall be reevaluated at each dental examination. Any one of the following is a sufficient criterion for such a classification:



- 1 Dental caries, decalcification, or tooth fractures extending beyond the dentinoenamel junction, or causing definitive symptoms;
- 2 Restorations with fractures or marginal defects;
- 3 Periodontal diseases or periodontium exhibiting;
- 4 nonspecific gingivitis. Inflammation of the gingiva characterized by changes in color, gingival form, position, surface appearance, bleeding upon brushing or flossing, or the presence of blood or exudate after probing with a periodontal probe;
- 5 slight or mild adult periodontitis. Progression of the gingival inflammation into the deeper periodontal structures and alveolar bone crest with accompanying periodontal probing depths of from 3 to 4mm, slight loss of connective attachment, and slight loss of alveolar bone;
- 6 moderate periodontitis. Gingival inflammation with destruction of the periodontal structures including radiographic or clinical evidence of loss of alveolar bone support, with possible early furcation involvement of multirooted teeth or tooth mobility;
- 7 stable or nonprogressive mucogingival conditions. This includes conditions such as irregular marginal contours, gingival clefts, and aberrant frena or muscle attachments, which could potentially progress, or pathosis but are currently stable and compatible with periodontal health; or
- 8 past history of periodontal disease or therapy when the disease is currently under control in a long-term maintenance program.
- 9 The presence of supragingival or subgingival tooth accumulated materials without concomitant periodontal disease.
- 10 Prosthodontics indicated. Edentulous areas, provisional/interim/temporary prostheses, defective prostheses, provisional crowns, large extracoronary direct restorations, or endodontically treated teeth without full coverage, that need prosthetic treatment but delay will not compromise the patients immediate health or masticating function.
- 11 Unerupted, nonfunctional, or malposed teeth without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal to prevent future pathologic conditions (e.g., unopposed or unerupted third molars, or malposed teeth which complicate plaque control measures).



- 12 Preventive dentistry requirements not fulfilled.
  - 13 Those conditions described in subparagraphs 4. through 7. above are not considered disqualifying for overseas, sea duty, or isolated duty assignment.
- (c) Class 3. Patients who have dental conditions that are likely to cause a dental emergency within 12 months. The following conditions have the potential to cause an emergency, and any one is sufficient criterion for disqualification for overseas or isolated duty assignment:
- 1 Periodontal diseases or periodontium exhibiting:
    - 2 advanced periodontitis. Significant progression of periodontitis with major loss of alveolar bone support and probable complex furcation involvement of multirooted teeth and increased tooth mobility. The periodontal probing depth may reach 7mm and deeper;
      - a. periodontal abscess;
      - b. acute necrotizing ulcerative gingivitis (NUG);
      - c. periodontal manifestations of systemic diseases and hormonal disturbances (e.g., acute herpetic gingivostomatitis);
      - d. refractory, rapidly progressive periodontitis. Rapid bone and attachment loss, or slow but continuous bone and attachment loss resistant to normal therapy; or
      - e. juvenile and prepubertal periodontitis, either localized or generalized.
  - 3 Acute or chronic pulpitis.
  - 4 Indication of periradicular pathosis with or without existing root canal filling which may require treatment.
  - 5 Presence of a tooth or teeth undergoing endodontic therapy.
  - 6 Stomatitis.
  - 7 Pericoronitis.
  - 8 Prosthodontics required to replace an existing prosthesis exhibiting dental caries, or a large defective amalgam restoration requiring replacement with a casting. Also, appliances required due to:
    - 9 insufficient masticatory function, active arch collapse from tooth loss, or essential performance of military duties (e.g., replacement of missing teeth for esthetics or phonetics);



- 10 soft tissue inflammation, such as papillary hyperplasia under a denture base;
  - 11 an essential prosthesis in need of repair in order to be functional; or
  - 12 a provisional, interim, or temporary prosthesis which cannot be maintained for a 12 month period.
  - 13 Unerupted, partially erupted, nonfunctional or malposed teeth associated with historical, clinical or radiographic evidence of pathosis, or with a high potential to cause a dental emergency.
  - 14 Soft or hard tissue lesions requiring an incisional or excisional biopsy for the definitive diagnosis and treatment of the lesions, including the period of time awaiting the results of the histopathologic examination.
  - 15 Appropriate postoperative treatment not yet completed, including suture removals for surgery and occlusal adjustments for restorative dentistry.
  - 16 All conditions requiring immediate treatment for relief of pain, traumatic injuries, or acute oral infections.
  - 17 Orthodontic therapy in progress, with either fixed or removable appliances.
- (4) Priority of Dental Treatment. To further indicate priority of treatment within a class, the following groupings shall be used when necessary (listed in order of decreasing priority).
- (a) Group 1. Coast Guard active duty personnel in receipt of orders to sea, overseas, or combat duty.
  - (b) Group 2. Coast Guard active duty personnel upon return from sea, overseas, or combat duty.
  - (c) Group 3. Other Coast Guard personnel.
  - (d) Group 4. Active duty personnel of other Services assigned to duty with the Coast Guard.
  - (e) Group 5. Active duty personnel of other Services.
  - (f) Missing Teeth and Existing Restorations.
  - (g) Markings shall be made on examination chart as follows:
    - 1 Missing Teeth. Draw a large "X" on the root(s) of each tooth that is not visible in the mouth.



- 2    Edentulous Mouth. Inscribe crossing lines, one extending from the maxillary right third molar to the mandibular left third molar and the other from the maxillary left third molar to the mandibular right third molar.
- 3    Edentulous Arch. Make crossing lines, each running from the uppermost aspect of one third molar to the lowest aspect of the third molar on the opposite side.
- 4    Amalgam Restorations. In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape, and block solidly.
- 5    Nonmetallic Permanent Restorations (includes oxyphosphate cements). In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape.
- 6    Gold Restorations. Outline and inscribe horizontal lines within the outline.
- 7    Combination Restorations. Outline showing overall size, location, and shape; partition and junction materials used and indicate each, as in "4." above.
- 8    Porcelain Facings and Pontics. Outline.
- 9    Acrylic Resin Facings and Pontics. Outline each aspect.
- 10   Porcelain Post Crowns. Outline the crown and approximate size and position of the post(s).
- 11   Acrylic Resin Post Crowns. Outline crown and approximate size and position of the post(s).
- 12   Porcelain Jacket Crowns. Outline each aspect.
- 13   Acrylic Resin Jacket Crowns. Outline each aspect.
- 14   Fixed Bridges. Outline each, showing overall size, location, teeth involved and shape by the inscription of diagonal lines in abutments and pontics.
- 15   Removable Appliances. Place an "X" through the missing tooth, place a line over replaced teeth and describe briefly in "Remarks."
- 16   Root Canal Fillings. Outline canal filled and black in solidly.



- 17 Apicoectomy. Draw a small triangle apex of the root of the tooth involved, the base line to show the approximate level of root amputation.
  - 18 Drifted Teeth. Draw an arrow from the designating number of the tooth that has moved; the point of the arrow to indicate the approximate position to which it has drifted. Under "Remarks" note the relationship to the drifted tooth in respect to occlusion.
- (h) If an individual is appointed or enlisted with dental defects which have been waived, the defects shall be described fully in the dental record under "Remarks" (Section I). (See FIGURE 4-C-3)
  - (i) The examining dental officer shall sign, date, and record the place of examination where indicated.
- (5) Diseases, Abnormalities, and Radiographs.
- (a) Markings on the examination chart of Diseases, Abnormalities, and Radiographs shall be made as follows:
    - 1 Caries. In the diagram of the tooth affected, draw an outline of the carious portion, showing size, location and shape, and block in solidly.
    - 2 Defective Restoration. Outline and block in solidly the restoration involved.
    - 3 Impacted Teeth. Outline all aspects of each impacted tooth with a single oval. Indicate the axis of the tooth by an arrow pointing in the direction of the crown.
    - 4 Abscess. Outline approximate size, form, and location.
    - 5 Cyst. Outline the approximate form and size in relative position of the dental chart.
    - 6 Periodontal Disease. Inscribe a horizontal continuous line on the external aspect of root(s) involved in a position approximating the extent of gingival recession or the clinical depth of the pocket. If known, indicate the position of the alveolar crest by a second continuous line in relative position to the line indicating the gingival tissue level.
    - 7 Extraction Needed. Draw two parallel vertical lines through all aspects of the tooth involved.



- 8 Fractured Tooth Root. Indicate fracture with a zigzag line on outline of tooth root.
- (b) A statement regarding hypersensitivity to procaine or any other drug known to the person for whom a Dental Record is prepared shall be entered under "Remarks." (Example: HYPERSENSITIVITY TO PROCAINE)
  - (c) Complete items A through E.
  - (d) The examining dental officer shall sign, date, and record the place of examination where indicated.
  - (e) NOTE: Section I, Subsections 4 and 5 of SF 603 are used to record findings of initial and replacement examinations. These charts shall not be altered thereafter.

## **SECTION II. PATIENT DATA**

- (1) Patient Data. Complete items 6 through 14 as indicated.

## **SECTION III. ATTENDANCE RECORD**

- (1) Restorations and Treatments (Completed during service) (Item 15).
  - (a) Record restorations or treatments provided a patient after the initiation of a Dental Record on the chart "Restorations and Treatments" of Section III, in accordance with the following:
    - 1 Carious Teeth Restored. In the diagram of the tooth involved, draw an outline of the restoration showing size, location and shape, and indicate the material used. Amalgam restorations would be outlined and blocked in, silicate cement restorations outlined only, etc.
    - 2 Extractions. Draw a large "X" on the root(s) of each tooth extracted.
    - 3 Root Canal Fillings. Outline each canal filled on the diagram of the root(s) of the tooth involved and block it in solidly.
    - 4 Apicoectomy. Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of tooth amputation.
    - 5 Bridge and Crowns. Outline and fill in as specified above.
    - 6 Removable Appliances. Place a line over numbers of replaced teeth and give a brief description under "Remarks."
    - 7 Unrecorded Operations and Conditions. Operations performed by other than Coast Guard dental officers subsequent to the original



examination will be indicated by the dental officer discovering the condition just as if they had been done by a Coast Guard dental officer. Make appropriate entries indicating the nature of the treatment and adding the abbreviation "CIV" or other abbreviation as the case may be. The date entered will be the date of the discovery.

- 8 Other. Similarly, note operations known to have been performed by Coast Guard dental officers whose identity is not recorded, except use the abbreviation "CGDO." The date entered shall be the date the operation is discovered. Account for teeth which are shown as missing in the chart, Missing Teeth and Existing Restorations, and which have erupted subsequently, by an entry in the following manner: "1 and 32," eruption noted, date, and signature of dental officer making the notation. Record other conditions of comparable importance in a similar manner.
- (b) Record a series of treatments for a specific condition not producing lasting changes in dental characteristics by entering of initial and final treatment dates (i.e., POT daily 1 AUG 87 thru 5 AUG 87 or Vin Tr. twice daily 1 AUG 87 thru 10 AUG 87).
  - (c) Authenticate each entry in this record by a written entry in the spaces provided under "Services Rendered."
- (2) Subsequent Disease and Abnormalities (Item 16). Chart subsequent conditions, in pencil only, using the instructions in Chapter 4-C.3.(6). Once treatment is completed and documented in item 17, erase pencil entry in item 16 and permanently transfer in ink to item 15 (Restorations and Treatments).
- (3) Services Rendered (Item 17). The accuracy and thoroughness in recording patient histories and treatment progress notes are essential elements in the diagnosis and treatment of the dental patient. In addition to the conventional listing of the tooth number and procedure, every effort shall be made to specifically identify dental materials used intraorally. Use trade names where possible. This includes, but is not limited to; bases and liners, metallic and nonmetallic restorative materials, denture frameworks and bases, impression materials, medicaments, and anesthesia. Record prescribed medications.
- (a) Standard S.O.A.P. format. The S.O.A.P. format shall be used to document all sickcall and emergency dental treatments, to document Type 1 and Type 2 examinations, and to record the results of the examination of patients in preparation for comprehensive treatment planning. S.O.A.P. format is not required to document ongoing delivery of treatment which has been previously planned. All entries are to be on the SF-603/603-A, item 17. The S.O.A.P. format uses a problem oriented record as a tool in management of patient care. The acronym is derived from the first letter of the first four record statements as follows:



- 1 **"S" Subjective data.** This data includes the reason for the visit to the dental clinic, and if appropriate, a statement of the problem (chief complaint) and the qualitative and quantitative description of the symptoms appropriate to the problem.
  - 2 **"O" Objective data.** A record of the type of examination and the diagnostic aids, including the ordering of radiographs, and the actual clinical findings, x-ray results, or laboratory findings appropriate to the problem. This is to include all the provider's findings such as carious teeth, inflammation, periodontal status, pocket depths, blood pressure measurement, etc.
  - 3 **"A" Assessment.** This portion is the assessment of the subjective data, objective data, and the problem statement which leads the provider to a diagnosis, e.g., "needs" (existing conditions or pathoses).
  - 4 **"P" Plan.** This is the plan of treatment to correct or alleviate the stated problems or needs, irrespective of the treatment capability of the dental treatment facility. Include recommended treatment and, as appropriate, possible complications, alternative treatment, and prognosis with and without intervention. Include consultations, a record of the specific treatment performed, pre- and postoperative instructions, prescriptions, and any deviations from the original treatment plan.
- (b) The following classification of tooth surfaces are listed in order of precedence and shall be used in connection with recording restorations of defective teeth:

| Surface                          | Designation |
|----------------------------------|-------------|
| Facial (Labial) (Anterior teeth) | F           |
| Buccal (Posterior teeth)         | B           |
| Lingual                          | L           |
| Occlusal (Posterior teeth)       | O           |
| Mesial                           | M           |
| Distal                           | D           |
| Incisal (Anterior teeth)         | I           |

- (c) Use combinations of designators to identify and locate caries, operations, or restorations in the teeth involved; for example, 8-MID would refer to the mesial, incisal, and distal aspects of the left mandibular cuspid; 30-MODF, the mesial, occlusal, distal, and facial aspects of a right mandibular first molar.



| <b>Surface</b>                        | <b>Designation</b> |
|---------------------------------------|--------------------|
| Mesial-Occlusal                       | MO                 |
| Distal-Occlusal                       | DO                 |
| Mesial-Incisal                        | MI                 |
| Distal-Incisal                        | DI                 |
| Occlusal-Facial                       | OF                 |
| Occlusal-Lingual                      | OL                 |
| Incisal-Facial                        | IF                 |
| Incisal-Lingual                       | IL                 |
| Mesial-Occlusal-Distal                | MOD                |
| Mesial-Occlusal-Facial                | MOF                |
| Mesial-Occlusal-Lingual               | MOL                |
| Mesial-Incisal-Distal                 | MID                |
| Mesial-Incisal-Facial                 | MIF                |
| Mesial-Incisal-Lingual                | MIL                |
| Distal-Occlusal-Facial                | DOF                |
| Distal-Occlusal-Lingual               | DOL                |
| Mesial-Occlusal-Distal-Facial         | MODF               |
| Mesial-Incisal-Distal-Facial          | MIDF               |
| Mesial-Occlusal-Distal-Facial-Lingual | MODFL              |
| Mesial-Incisal-Distal-Facial-Lingual  | MIDFL              |

- (d) The use of abbreviations is not mandatory but is desirable for purposes of brevity in view of the limited space available in the dental record for recording services rendered. Whenever there is a possibility of misinterpretation due to the use of abbreviations, dental operations shall be written in full. When abbreviations are used, they shall conform to the following:

| <b>Operation, Condition, or Treatment</b> | <b>Abbreviation</b> |
|---|---------------------|
| Abrasion                                  | Abr.                |
| Abscess                                   | Abs.                |
| Acrylic                                   | Acr.                |
| Adjust (ed)(ment)                         | Adj.                |
| Alveolectomy                              | Alvy.               |
| Amalgam                                   | Am.                 |



|  |            |
|--|------------|
| Anesthesia   | Anes.      |
| Apicectomy   | Apcy.      |
| Base   | B.         |
| Bridge (denotes fixed unless otherwise noted)          | Br.        |
| Caries   | Car.       |
| Calculus   | Cal.       |
| Cavity Varnish   | C.Var.     |
| Cement   | Cem.       |
| Composite Resins                                       | Comp. Res. |
| Crown  | Cr.        |
| Deciduous  | Dec.       |
| Defective  | Def.       |
| Denture (full unless otherwise noted)                  | Dtr.       |
| Drain.   | Drn.       |
| Dressing   | Drs.       |
| Equilibrate (action)                                   | Equil.     |
| Eugenol  | Eug.       |
| Examination  | Exam.      |
| Extraction (ed) (Uncomplicated unless otherwise noted) | Ext.       |
| Filling(s)   | Fil.       |
| Fluoride   | Fl.        |
| Fracture(s)  | Frac.      |
| General  | Gen.       |
| Gingival (itis) (state type in parenthesis).           | Ging.      |
| Gutta percha   | G.P.       |
| Impacted (ion)   | Imp.       |
| Impression   | Impr.      |
| Incised  | Inc.       |
| Inlay  | Inl.       |
| Inserted   | Ins.       |
| Maxillary  | Max.       |
| Mandibular   | Man.       |
| Partial  | Pr.        |



|                          |         |
|--------------------------|---------|
| Parietal                 | Par.    |
| Periapical               | Per.    |
| Pericoronitis            | Percor. |
| Periodontitis            | Perio.  |
| Porcelain                | Porc.   |
| Post Operative Treatment | POT.    |
| Prepared (ation)         | Prep.   |
| Prophylaxis              | Pro.    |
| Reappoint (ment)         | Reapt.  |
| Recement (ed)            | Recem.  |
| Reconstruct (ed)         | Rct.    |
| Reduce (d)               | Red.    |
| Regional                 | Rel.    |
| Repaired                 | Rpd.    |
| Sedative (ation)         | Sed.    |
| Sequestrum               | Seq.    |
| Surgical                 | Surg.   |
| Suture (s)(d)            | Su.     |
| Treatment (ed)           | Tr      |
| Unerupted                | Uner.   |
| Vincent's                | Vin.    |
| Zinc Chloride            | ZnCl.   |

- (4) Space is provided in the lower right margin under Section III for the patient's name which is for convenience in filing in the dental record. Record the last name in capital letters. Do not abbreviate any part of the name.

4. SF-603-A (Dental Continuation).

- a. General. Use a SF-603-A whenever the original SF-603 becomes filled or when the record cannot be satisfactorily brought up-to-date by entries on the appropriate chart.

b. Detailed Instructions.

- (1) Enter individual's name and SSN in the space provided on the right margin of both the front and back side of the form.



- (2) Number the continuation sheet in the upper right corner following the phrase "DENTAL-Continuation." Thus, the earliest SF-603-A is labeled "DENTAL-Continuation #1" and subsequent sheets are labeled "DENTAL-Continuation #2", "DENTAL-Continuation #3", etc. (See FIGURE 4-C-4).
  - (3) File the SF-603-A forms on top of the SF-603 form in reverse chronological order, i.e., the most recent on top.
5. SF-513, Consultation Sheet.
  - a. Purpose. SF-513 shall be used whenever a patient is referred to another facility for evaluation or treatment.
  - b. Detailed Instructions. Complete the form as detailed in paragraph 4-B-14.b.
6. Lost Dental Records.
  - a. Forward "stray" dental records, disposition of which cannot be determined, to Commandant (G-PIM) with a letter of explanation.
  - b. When a Dental Record is missing, prepare a new record. Prominently mark the Dental Record Cover (CG-3443-2) and the Health Record, Dental (SF-603) "REPLACEMENT." Request the old Dental Record from the individual's last unit or Commandant (G-PIM).
  - c. In case a lost Dental Record is recovered, make entries in the recovered record of any data recorded in a replacement record, then destroy the replacement record.
7. Special Dental Records Entries. When dental treatment is refused, make an appropriate entry on the SF-603/603-A, **signed by both the dental officer and patient.**
8. Dental Examination Requirements.
  - a. Any peculiarities or deviations from normal are particularly valuable for identification purposes and shall be recorded on SF-603 under "Remarks." Abnormalities such as erosion, mottled enamel, hypoplasia, rotation, irregularity of alignment and malocclusion of teeth, presence of supernumerary teeth, denticles, Hutchinson's incisors, fractures of enamel or teeth, abnormal interdental spaces, mucosal pigmentation, leukoplakia, diastema, hypertrophied frenum labium, torus palatinus and torus mandibularis, embedded foreign bodies and descriptions of unusual restorations or appliances are, when noted, especially useful in this connection. Malocclusion shall be simply and clearly described. Dentures and other removable dental appliances shall also be described under "Remarks".
  - b. When all teeth are present, and free of caries or restorations, take special effort to discover and record any abnormalities, however slight. If no caries, restorations, or abnormalities are found, make an entry to that effect on SF-603 under "Remarks."



- c. Inquire about the patients' tobacco use during routine dental examinations and document. Advise users of the health risks associated with tobacco use, the benefits of stopping, and where to obtain assistance in stopping if available. Advise all pregnant tobacco users of the health risks to the fetus.
  - d. Oral hygiene and periodontal status at time of examination shall be recorded. Upon initial examination, complete items 5A-5C, SF-603, with additional comments placed in "Remarks" if needed. For all subsequent examinations, describe oral hygiene level and periodontal status in item 17 of SF-603/603-A.
  - e. For all patients 16 years of age or older, blood pressure readings shall be taken and recorded on the CG-5605 at initial and subsequent dental examinations. Although not required, the blood pressure may also be recorded on the SF-603/603-A in the "O" portion of the SOAP entry.
9. Recording of Dental Treatments on SF-600. Make entries of dental treatment on SF-600 when the patient is on the sick list and when treatment is related to the condition for which the patient is admitted. Such entries shall be made and signed by the dental officer. Notes concerning conditions of unusual interest and of medical or dental significance may be made when appropriate.



FIGURE 4-C-1

# U. S. COAST GUARD

## DENTAL RECORD

### PRIVACY ACT STATEMENT: HEALTH CARE RECORDS

- AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):**  
Section 632 of Title 14 United States Code and Sections 1071-1087, Title 10 United States code, Executive Order 9397.
- PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:**  
The purpose for requesting information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The social Security Number (SSN) necessary to identify the person and records.
- ROUTINE USES:**  
This information may be used to plan and coordinate health care. It may be used to provide medical treatment, conduct research, teach, compile statistical data, determine suitability of persons for service or assignment, implement preventive health and communicative disease control program; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification of patients to other Federal, State and local agencies upon request in the pursuit of their official duties; and report medical conditions required by law to federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.
- The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.
- No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

|               |                          |             |                        |                        |                                  |                                   |
|---------------|--------------------------|-------------|------------------------|------------------------|----------------------------------|-----------------------------------|
|               |                          |             |                        |                        |                                  |                                   |
| LAST NAME     | FIRST NAME               | MIDDLE NAME | SOCIAL SECURITY NUMBER |                        | DATE OF BIRTH (DAY, MO, YR)      |                                   |
| GRADE OR RATE | CHANGES IN GRADE OR RATE |             |                        | BLOOD TYPE (Check one) |                                  |                                   |
|               |                          |             |                        |                        | <input type="checkbox"/> O       | <input type="checkbox"/> A        |
|               |                          |             |                        |                        | <input type="checkbox"/> B       | <input type="checkbox"/> AB       |
|               |                          |             |                        |                        | RH FACTOR (Check one)            |                                   |
|               |                          |             |                        |                        | <input type="checkbox"/> POSTIVE | <input type="checkbox"/> NEGATIVE |

**DRUG SENSITIVITY**  
SPECIFIC DRUG(S)

ATTACH TO FRONT OF CHART JACKET

DEPT OF TRANSP. USCG CG 3443-2



Figure 4-C-2

| <b>DENTAL HEALTH QUESTIONNAIRE</b>  |     |                                  |            | Personal Data - Privacy Act of 1974 |                      |            |            |
|---|-----|----------------------------------|------------|-------------------------------------|----------------------|------------|------------|
| ARE YOU IN FLIGHT STATUS? . . . YES <input type="checkbox"/> NO <input type="checkbox"/>  |     |                                  |            | OCCUPATION/JOB: _____               |                      |            |            |
| ARE YOU PRESENTLY ILL OR UNDER THE CARE OF A PHYSICIAN? . . . YES <input type="checkbox"/> NO <input type="checkbox"/>  |     |                                  |            |                                     |                      |            |            |
| IF YES, PLEASE DESCRIBE: _____  |     |                                  |            |                                     |                      |            |            |
| ALLERGIES (including medication, Latex, jewelry, metal, etc.): _____  |     |                                  |            |                                     |                      |            |            |
| CURRENT MEDICATIONS: _____<br>(including aspirin, over-the-counter medications, etc.): _____  |     |                                  |            |                                     |                      |            |            |
| HISTORY OF HOSPITALIZATIONS: _____  |     |                                  |            |                                     |                      |            |            |
| ANY FAMILY HISTORY OF: Heart Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> |     |                                  |            |                                     |                      |            |            |
| HAVE YOU EVER HAD OR DO YOU NOW HAVE:   |     |                                  |            |                                     |                      |            |            |
|   | Yes | No                               | Don't Know |                                     | Yes                  | No         | Don't Know |
| Epilepsy or Seizures  |     |                                  |            | Hemophilia                          |                      |            |            |
| Fainting or dizziness   |     |                                  |            | Bruise or bleed easily              |                      |            |            |
| Anxiety reaction  |     |                                  |            | Heart problems/Angina               |                      |            |            |
| Stroke  |     |                                  |            | Hypertension                        |                      |            |            |
| Glaucoma  |     |                                  |            | Rheumatic fever                     |                      |            |            |
| Cold Sores (Herpes)   |     |                                  |            | Heart murmur                        |                      |            |            |
| Persistent cough  |     |                                  |            | Mitral valve prolapse               |                      |            |            |
| Emphysema   |     |                                  |            | Congenital heart lesions            |                      |            |            |
| TB/PPD positive   |     |                                  |            | Heart surgery                       |                      |            |            |
| Asthma  |     |                                  |            | Prosthetic heart valve              |                      |            |            |
| Hay Fever   |     |                                  |            | Pacemaker                           |                      |            |            |
| Sinus problems  |     |                                  |            | Blood transfusions                  |                      |            |            |
| Anemia  |     |                                  |            | Liver disease                       |                      |            |            |
| Sickle cell disease   |     |                                  |            | Yellow jaundice                     |                      |            |            |
| G-6-PD deficiency   |     |                                  |            | Hepatitis - type: _____             |                      |            |            |
|   |     |                                  |            | Ulcers                              |                      |            |            |
|   |     |                                  |            | Kidney problems                     |                      |            |            |
|   |     |                                  |            | Venereal disease                    |                      |            |            |
|   |     |                                  |            | Diabetes                            |                      |            |            |
|   |     |                                  |            | Thyroid disease                     |                      |            |            |
|   |     |                                  |            | HIV/AIDS                            |                      |            |            |
|   |     |                                  |            | Arthritis                           |                      |            |            |
|   |     |                                  |            | Painful joints (incl. jaw)          |                      |            |            |
|   |     |                                  |            | Prosthetic joint                    |                      |            |            |
|   |     |                                  |            | Hives                               |                      |            |            |
|   |     |                                  |            | Steroid medication                  |                      |            |            |
|   |     |                                  |            | Drug addiction                      |                      |            |            |
|   |     |                                  |            | Alcoholism                          |                      |            |            |
|   |     |                                  |            | Unexplained weight change           |                      |            |            |
|   |     |                                  |            | Cancer/radiation therapy            |                      |            |            |
| HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD? -----   |     |                                  |            |                                     |                      |            |            |
| HAVE YOU EVER BEEN TOLD THAT YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT? -----  |     |                                  |            |                                     |                      |            |            |
| FEMALES: Are you taking birth control pills? -----  |     |                                  |            |                                     |                      |            |            |
| Are you or might you be pregnant? Estimated delivery: _____   |     |                                  |            |                                     |                      |            |            |
| DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? Please describe: _____   |     |                                  |            |                                     |                      |            |            |
| _____   |     |                                  |            |                                     |                      |            |            |
| Patient's signature   |     |                                  |            |                                     |                      | Date       |            |
| SUMMARY OF PERTINENT FINDINGS / RECOMMENDED TREATMENT MODIFICATIONS (Dentist's use only) B/P: _____   |     |                                  |            |                                     |                      |            |            |
| _____   |     |                                  |            |                                     |                      |            |            |
| _____   |     |                                  |            |                                     |                      |            |            |
| _____   |     |                                  |            |                                     |                      |            |            |
| _____   |     |                                  |            |                                     |                      |            |            |
| WELLNESS SCREEN:  |     |                                  |            |                                     |                      |            |            |
| Tobacco use _____   |     | Exercise _____                   |            | Diet/nutrition _____                |                      |            |            |
| Alcohol use _____   |     | Stress _____                     |            | Seat belt use _____                 |                      |            |            |
| Dental Officer's Signature  |     |                                  |            |                                     |                      | Date       |            |
| PATIENT'S IDENTIFICATION  |     | PATIENT'S NAME (Last, First, MI) |            |                                     |                      | SEX        |            |
|   |     | DATE OF BIRTH                    |            | RELATIONSHIP TO SPONSOR             |                      | SERVICE    |            |
|   |     | SPONSOR'S NAME                   |            |                                     |                      | RANK/GRADE |            |
|   |     | SSN                              |            |                                     | ORGANIZATION/COMMAND |            |            |
|   |     | PHONE #: DAY                     |            | EVENING                             |                      |            |            |

DEPT. OF TRANSP., USCG, CG-5605 (4-96)











Figure 4-C-4

**PERIODONTAL CHART** Personal data - Privacy Act of 1974

Bleeding/purulence (+)

Attachment level CEJ to BP

Pocket depths FM to BP

Mark (fill, 3/4 crown, and pontics in blue)

Purification invasion

Grade 1  $\triangle$

Grade 2  $\triangle$

Grade 3  $\triangle$

Record on Occlusal Outlines

Mobility (1,2,3)

Poor contact  $\nearrow$

Open contact  $\parallel$

Food impaction  $\downarrow$

Caries and faulty restorations outlined in red

Pocket depths FGM to BP

Attachment level CEJ to BP

Bleeding/purulence (+)

Bleeding/purulence (+)

Attachment level CEJ to BP

Pocket depths FGM to BP

**KEY**

Horiz. lines = 2mm

FGM = free gingival margin

BP = base of pocket

Draw FGM with continuous blue line relative to CEJ

Mark pocket area in red on root surface

Draw mucogingival junction as black continuous line

Block out missing teeth and/or roots

Pocket depths FGM to BP

Attachment level CEJ to BP

Bleeding/purulence (+)

PLACE OF EXAMINATION  EXAMINER  DATE

PATIENT IDENTIFICATION

|  |                          |                   |                                |                     |
|--|--------------------------|-------------------|--------------------------------|---------------------|
| SEX  | GRADE, RATE, OR POSITION | ORGANIZATION/UNIT | COMPONENT OR BRANCH            | PHONE: (W)<br>(H)   |
| PATIENT'S LAST NAME - FIRST NAME - MIDDLE NAME |                          |                   | DATE OF BIRTH (Day-Month-Year) | SOCIAL SECURITY NO. |

NAVMED 6660/2 (3/90)



Figure 4-C-4 (cont'd)

**PERIODONTAL CHART**

|   |   |      |     |      |    |    |    |
|---|---|------|-----|------|----|----|----|
| <b>Patient's Name:</b> _____  | <b>SSN:</b> _____   |      |     |      |    |    |    |
| <b>Chief Complaint:</b><br>_____  |   |      |     |      |    |    |    |
| <b>Pertinent Med Dent Hx:</b>   | <table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;">Age</td> <td style="padding: 2px 10px;">Sex</td> <td style="padding: 2px 10px;">Race</td> <td style="padding: 2px 10px;">HT</td> <td style="padding: 2px 10px;">WT</td> <td style="padding: 2px 10px;">BP</td> </tr> </table> | Age  | Sex | Race | HT | WT | BP |
| Age   | Sex   | Race | HT  | WT   | BP |    |    |
| <b>Extraoral Findings:</b><br>_____   |   |      |     |      |    |    |    |
| <b>Intraoral Findings:</b><br>_____   |   |      |     |      |    |    |    |
| <b>Periodontal Findings:</b><br>_____                                       |   |      |     |      |    |    |    |
| <b>Occlusion:</b><br>_____  |   |      |     |      |    |    |    |
| <b>Pediographic Assesment:</b><br>_____                                     |   |      |     |      |    |    |    |
| <b>Etiology/Contributing Factors:</b><br>_____                              |   |      |     |      |    |    |    |
| <b>Diagnosis:</b><br>_____  |   |      |     |      |    |    |    |
| <b>Prognosis (1-5 years) (Circle One):</b> Good    Fair    Poor    Hopeless |   |      |     |      |    |    |    |
| <b>Overall Individual:</b> _____  |   |      |     |      |    |    |    |
| <b>Tentative Treatment Plan:</b><br>_____<br>_____<br>_____                 |   |      |     |      |    |    |    |



## Section D - Clinical Records.

1. Purpose and Background. The Clinical Record (CG-3443-1) is the chronological medical and dental record of a nonactive duty beneficiary (dependent or retiree) eligible for health care at a Coast Guard facility. The primary reasons for compiling a clinical record are:
  - a. To develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result.
  - b. to protect the Government, the individual concerned, and the individual's dependents:  
It may be used;
    - (1) to provide, plan and coordinate health care;
    - (2) to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies;
    - (3) to compile statistical data; for research; to teach health services personnel;
    - (4) to determine suitability of persons for service or assignments;
    - (5) to adjudicate claims and determine benefits; for law enforcement or litigation;
    - (6) to evaluate care provided; and
    - (7) to evaluate personnel and facilities for professional certification and accreditation.
  - c. to aid in identifying deceased persons when other means may be inadequate.
2. Contents of Clinical Records.
  - a. Each clinical record shall consist of CG-3443-1 with dental and medical records arranged in the following bottom to top sequence:
    - (1) Left Side - Dental: CG-3443-2 Dental Record Cover\* with CG-5266 (Drug Sensitivity Sticker)\*, containing the following:
      - (a) SF-522, Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures\*
      - (b) SF-603-A, Dental Record - Continuation\*
      - (c) SF-603, Dental Record\*
      - (d) CG-5605, Dental Health Questionnaire\*



(2) Right Side - Medical:

- (a) PHS-731, International Certificate of Vaccination\*, attached to the lower right corner of the inside of the Clinical Record Cover
- (b) DD-1141, Record of Occupational Exposure to Ionizing Radiation\*
- (c) SF-507, Continuation Sheet\*\*
- (d) SF-602, Syphilis Record\*
- (e) SF-601, Immunization Record\*
- (f) DD-771, Spectacle Order Form\*
- (g) SF-520, Electrocardiographic Report\*
- (h) SF-519, Radiographic Reports
- (i) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display\*)
- (j) SF-541, Gynecologic Cytology\*
- (k) SF-515, Tissue Examination\*
- (l) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures\*
- (m) SF-513, Consultation Sheet\*
- (n) SF-502, Narrative Summary\*
- (o) CG-5447, Occupational Medical Surveillance and Evaluation Program\*
- (p) SF-93, Report of Medical History\*
- (q) SF-88, Report of Medical Examination\*
- (r) SF-558, Emergency Care and Treatment
- (s) SF-600, Chronological Record of Medical Care
- (t) DD-2766, Adult Preventive and Chronic Care Flowsheet Form
- (u) CG-5266, Drug Sensitivity Sticker\*

\* When required

\*\* SF-507's are attached to and filed after the form is continued



- b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 89 on top of SF-600 dated 20 MAY 86.
  - c. Enter all dates on Clinical Record forms, including the Clinical Record Cover, in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.
3. Extraneous Attachments. In order to ensure that the clinical record is an accurate, properly documented, concise and dependable record of the medical and dental history of the individual, keep extraneous attachments to a minimum. When they are necessary, file them beneath all other forms.
4. Opening Clinical Records. Open a Clinical Record when an eligible non-active duty beneficiary initially reports to a Coast Guard health care facility for treatment.
5. Terminating Clinical Records. The Clinical Record shall be terminated four years after the last record entry. Make an entry on SF-600 explaining the circumstances under which the record was terminated. Forward the record to:

**Dependent Records:**

National Personnel Records Center  
GSA (Civilian Personnel Records)  
11 Winnebago Street  
St. Louis, MO 63118

**Retiree Records:**

National Personnel Records  
Center (MPR)  
9700 Page Blvd.  
St. Louis, MO 63132

6. Custody of Clinical Records.
- a. Clinical Records shall be retained in the custody of the Chief, Health Services Division of the unit providing care. At times when there is no medical or dental officer, the clinical record will become the responsibility of the senior health services department representative.
  - b. The name, grade, or rate of the health care provider making entries in clinical records shall be typed, stamped, or printed under their official signatures. Do not use facsimile signature stamps.
  - c. If an erroneous entry is made in a Clinical Record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.
  - d. Each health care provider is responsible for the completeness of the entries they make on any medical or dental form in the Clinical Record.
  - e. Nothing shall be removed from the Clinical Record except under conditions specified in this Manual.



7. Safekeeping of Clinical Records. Clinical Records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).
- f. Since Clinical Records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).
  - g. Except as contained in the The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3(series), the information contained in Clinical Records shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.
8. Transfer of Clinic Records.
- a. When dependents of active duty personnel accompany their sponsor to a new duty station, the Chief, Health Services Division, his designee, the Executive Officer, or the senior health services department representative shall ensure that the "TRANSFERRED TO" line of the health Record Receipt form, NAVMED 6150/7, is completed in accordance with Chapter 6-B-5 of this Manual.
  - b. A DD 877 shall be initiated for each record transferred. Records will **be mailed via certified mail with return receipt**, to the Coast Guard clinic serving the gaining unit. Express mail and Federal Express should be used only when absolutely necessary and not as a general rule. In instances where the family member will not be located near a Coast Guard Clinic, the record may be mailed to the appropriate MTF. This form can be located on the internet at;  
<http://web1.whs.osd.mil/ICDHOME/DD-0999.htm>
  - c. If the family members will no longer receive care through a military primary care manager, the family member may be given a copy of the clinical record contents to carry with them. The original clinical record will be retained at the clinic serving the unit where the sponsor was last assigned.
  - d. Clinics will give family members written information containing address and POC information to facilitate requests for record copies after transfer. All requests for clinical record copies must be in writing. The family member may request that a copy of the record be forwarded to their new care provider once they arrive at the new location, or they may request that the original record be forwarded to their new military primary care manager once they arrive at the new location. In these cases, the clinic shall send a copy of the clinical record contents to the care provider within 10 working days of receipt of the written request. If the clinic cannot comply with this requirement for some reason, the family member will be notified within 10



working days of the request of a projected date when the record copy will be available.

- e. In any instance where there is concern about potential loss of the clinical record, or that its contents may become unavailable to the treating clinic or its provider, the Clinic Administrator or the Chief, Health Services Division shall direct that copies of parts or all of the clinical record shall be made and retained at the clinic.
- f. Originals and copies of clinical records shall be retained and subsequently archived in accordance with directions contained in the Paperwork Management Manual, COMDTINST 5212.12(series).

9. Lost, Damaged, or Destroyed Clinical Records.

- a. If a Clinical Record is lost or destroyed, the unit which held the record shall open a new record. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing Clinical Record is recovered, insert in it any additional information or entries from the replacement record, then destroy the replacement record cover.
- b. Clinical Records which become illegible, thus destroying their value as permanent records, shall be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record became illegible. The new record shall be stamped or marked "DUPLICATE" on the cover. The circumstances necessitating the duplication shall be explained on the SF-600. Forward Clinical Records replaced by duplicate records to the National Personnel Records Center.

10. Clinical Record Forms.

- a. CG-3443-1 (Clinical Record Cover). (See FIGURE 4-D-1)

(1) General. The Clinical Record Cover is used whenever a Clinical Record is opened on dependents or retirees.

(2) Detailed Instructions.s

- (a) Last Name. Record the last name in all capital letters.

**SMITH**

- (b) Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

SMITH,            Helen            (n)

**Last Name    First Name    Middle Name**



- (c) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 3 FEB 77.
- (d) Social Security Number. Enter sponsor's SSN.
- (e) Status. Check the appropriate block; i.e., Retiree USCG, Dependent USPHS, etc.
- (f) Other. Use this block to indicate special status or other information useful for either proper monitoring of the patient or for aid in indentifying the patient or record.
- (g) Occupational Monitoring. Indicate the reason for occupational monitoring if monitoring is required.
- (h) Med-Alert. Check this block to indicate that the patient has a medical problem that must be considered in rendering treatment; i.e., allergy, diabetes, cardiac problems, etc. Describe the specific medical problem within the medical record on Problem Summary List, NAVMED 6150/20.

b. SF-522 (Authorization for Anesthesia, Operations, etc.).

- (1) Complete SF-522 describing the general nature of the procedure and have the patient sign prior to administering anesthesia (local or general) except for dental anesthesia. Also, complete SF-522 prior to administering immunizing agents.

Insert the form immediately behind Consultation Sheet (SF-513) or as indicated in Section 4-D-2. Complete the form as indicated in FIGURE 4-D-2.



Figure 4-D-1

|           |            |             |               |                                   |
|-----------|------------|-------------|---------------|-----------------------------------|
| LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER (OPTIONAL) |
|-----------|------------|-------------|---------------|-----------------------------------|

# U.S. Coast Guard

## CLINICAL RECORD

### PRIVACY ACT STATEMENT; HEALTH CARE RECORDS

**1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):**  
Section 632 of Title 14, United States Code and Sections 1071-1087, Title 10 United States Code, Executive Order 9397 and Title 5 United States Code Section 7901.

**2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:**  
The purpose for requesting personal information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The Social Security Number (SSN) is not mandatory; however it is desirable for identification and recall of records.

**3. ROUTINE USES:** The information may be used to plan and coordinate health care. It may be used to provide medical treatment; conduct research; teach; compile statistical data; implement preventive health and communicative disease control programs; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification and hospital accreditation; conduct authorized investigations; provide physical qualifications of patients to other Federal, State and local agencies upon request in the pursuit of their official duties; and report medical conditions required by law to Federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.

**4.** The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.

**5.** No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

### STATUS

DEPENDENT ☐

RETIREE ☐

USCG ☐

USPHS ☐

USN ☐

USMC ☐

USAF ☐

USA ☐

CIVILIAN ☐

EMPLOYEE ☐

OTHER ☐ SPECIFY \_\_\_\_\_

OCCUPATIONAL MONITORING ☐ SPECIFY \_\_\_\_\_

### MED-ALERT ☐

DEPT. OF TRANSP., USCG, CG-3443-1 (10-77)



Figure 4-D-2

|   |  |   |
|---|--|---|
| <b>MEDICAL RECORD</b>   | <b>REQUEST FOR ADMINISTRATION OF ANESTHESIA<br/>AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES</b> |   |
| <b>A. IDENTIFICATION</b>  |  |   |
| 1. OPERATION OR PROCEDURE _____   |  |   |
| <b>B. STATEMENT OF REQUEST</b>  |  |   |
| <p>1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____</p> <p style="text-align: center;"><small>(Description of operation or procedure in layman's language)</small></p> <p>_____</p> <p>_____</p> <p>which is to be performed by or under the direction of Dr. _____</p> <p>2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.</p> <p>3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.</p> <p>4. Exceptions to surgery or anesthesia, if any, are: _____</p> <p style="text-align: center;"><small>(If "none", so state)</small></p> <p>5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.</p> <p>6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:</p> <p style="margin-left: 40px;">a. The name of the patient and his/her family is not used to identify said pictures.</p> <p style="margin-left: 40px;">b. Said pictures be used only for purposes of medical/dental study or research.</p> <p style="text-align: center;"><small>(Cross out any parts above which are not appropriate)</small></p> |  |   |
| <b>C. SIGNATURES</b>  |  |   |
| <small>(Appropriate items in Parts A and B must be completed before signing)</small>  |  |   |
| 1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.   |  |   |
| _____<br><small>(Signature of Counseling Physician/Dentist)</small>   |  |   |
| 2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.  |  |   |
| _____<br><small>(Signature of Witness, excluding members of operating team)</small>   | _____<br><small>(Signature of Patient)</small>   | _____<br><small>(Date and Time)</small> |
| 3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____  |  |   |
| sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.  |  |   |
| _____<br><small>(Signature of Witness, excluding members of operating team)</small>   | _____<br><small>(Signature of Sponsor/Legal Guardian)</small>  | _____<br><small>(Date and Time)</small> |
| <b>PATIENT'S IDENTIFICATION</b><br><small>(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)</small>  | <b>REGISTER NO.</b><br>_____   | <b>WARD NO.</b><br>_____                |

STANDARD FORM 522 (Rev. 10-76)  
 General Services Administration &  
 Interagency Comm. on Medical Records  
 FPMR 101-11.806-8  
 522-109

NSN 7540-00-634-4165



## Section E - Employee Medical Folders.

1. Purpose and Background. The Employee Medical Folder (EMF), (SF-66 D), is the chronological medical record of Federal employees eligible for health care at Coast Guard facilities. These are the primary reasons for compiling an EMF.
  - a. Develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of care rendered, including diagnosis, treatment, and end result.
  - b. To protect the Government and the individual concerned.
  - c. The information in the EMF is routinely used: to provide, plan and coordinate health care; to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies; to compile statistical data; for research; to teach health services personnel; to determine suitability of persons for service or assignments; to adjudicate claims and determine benefits; for law enforcement or litigation; to evaluate care provided; and to evaluate personnel and facilities for professional certification and accreditation.
2. Custody of Employee Medical Folders (EMF's).
  - a. EMF's are the property of the Federal government handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).
    - (1) Since EMF's contain personal information of extremely critical or sensitive nature, they are considered class III records according to The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), requiring maximum security (high security locked cabinets or areas). Except as contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), the information contained in the EMF shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the responsibility of the requester to obtain the consent.
  - b. EMF's shall be retained in the custody of the medical officer of the unit at which the individual is employed. At no time shall individual employees keep or maintain their own records.
  - c. Individuals may examine their EMF in the presence of a health services department representative, providing it does not interrupt the scheduled mission of the unit and



there is no information contained therein which would be detrimental to the individual's mental well-being.

- d. Health services personnel making entries in EMF shall ensure that all entries, including signatures, are neat and legible. Signature information shall include the name and grade or rate. Do not use facsimile signature stamps.
  - e. If an erroneous entry is made in an EMF, draw a diagonal line through the complete entry. Make an additional entry showing wherein and to what extent the original entry is in error.
  - f. Health services personnel are responsible for the completeness of the entries made on any form while the EMF is in their custody. No sheet shall be removed from the EMF except under conditions specified in this Manual.
  - g. Health services personnel shall ensure that, if EMF's are located in the same office as the Official Personnel Folder (OPF), the records are maintained physically apart from each other.
3. Contents of the Employee Medical Folders.
- a. Each medical folder shall consist of SF-66 D (Employee Medical Folder) with medical records arranged in the following bottom to top sequence:
    - (1) Left Side Dental: Leave blank.
    - (2) Right Side - Medical:
      - (a) PHS-731, International Certificate of Vaccination\*, attached to the lower right corner of the inside of the EMF
      - (b) DD-1141, Record of Occupational Exposure to Ionizing Radiation\*
      - (c) SF-507, Continuation Sheet\*\*
      - (d) CG-5447, Occupational Medical Surveillance and Evaluation Program\*
      - (e) SF-602, Syphilis Record\*
      - (f) SF-601, Immunization Record\*
      - (g) DD-771, Spectacle Order Form\*
      - (h) SF-520, Electrocardiographic Report\*
      - (i) SF-519, Radiographic Reports
      - (j) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display\*)



- (k) SF-541, Gynecologic Cytology\*
  - (l) SF-515, Tissue Examination\*
  - (m) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures\*
  - (n) SF-513, Consultation Sheet\*
  - (o) SF-502, Narrative Summary\*
  - (p) SF-93, Report of Medical History\*SF-88, Report of Medical Examination\*
  - (q) SF-558, Emergency Care and Treatment\*
  - (r) SF-600, Chronological Record of Medical Care
  - (s) CG-5357, Outpatient Record
  - (t) DD-2766, Adult Preventive and Chronic Care Flowsheet
  - (u) CG-5266, Drug Sensitivity Sticker\*
  - (v) \* When required
  - (w) \*\* SF-507's are attached to and filed after the form is continued.
- b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 87 on top of SF-600 dated 20 MAY 86.
- c. Enter all dates in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.
4. Accountability of Disclosures. The accountability of disclosure of records, as required by the Privacy Act of 1974, will be maintained in accordance with Chapter 8, of COMDTINST M5260.2 (series). The information will be retained for five years after the last disclosure or for the life of the record, whichever is longer.
5. Opening Employee Medical Folder. Open an EMF when an eligible Federal employee initially reports for treatment.
6. Terminating Employee Medical Folders. Terminate the EMF in accordance with the Coast Guard Paperwork Management Manual, COMDTINST 5212.12 (series). Make an entry on SF-600 explaining the circumstances under which the folder was terminated.



7. Transferring to Other Government Agencies. When transferring an EMF to other agencies, complete a Request for Medical/Dental Records or Other Information (DD-877).
8. Lost, Damaged, or Destroyed Employee Medical Folders.
  - a. If an EMF is lost or destroyed, the unit which held the record shall open a complete new Employee Medical Folder. Stamp or mark "REPLACEMENT" on the cover. If the missing folder is recovered, insert in it any additional information or entries from the replacement folder, then destroy the replacement folder.
  - b. EMF's which become illegible, thus destroying their value as permanent records, will be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Stamp or mark "DUPLICATE" on the new record cover. Document the circumstances necessitating the duplication on an SF-600. Forward EMF's replaced by duplicate records to the National Personnel Records Center.
9. SF-66 D (Employee Medical Folder). (See FIGURE 4-E-1) Detailed instructions are:
  - a. Last Name. Record the last name in all capital letters.  
**BROOKS**
  - b. Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.  
  
**BROOKS      Cecilia      (n)**  
**Last Name    First Name    Middle Name**
  - c. Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 8 JUN 62.
  - d. Social Security Number. Enter SSN.



Figure 4-E-1

Standard Form 66 D  
April 1985  
U.S. Office of Personnel Management  
FPM Supplement 293-31  
66-501

## EMPLOYEE MEDICAL FOLDER

### CAUTION MEDICAL RECORD—RESTRICTED USAGE

1. Your use of the contents of this folder must be in accordance with the instructions in The Guide to Personnel Record Keeping.
2. You must safeguard this folder and its contents while it is in your possession.
3. You are required to keep this folder in a locked place when it is not in use.
4. You are normally prohibited from disclosing the contents of this folder to anyone; exceptions are those officials of your agency demonstrating an official need for the record and those other disclosures permitted by the Privacy Act of 1974 (5 U.S.C. 552a).
5. After use, promptly return this folder to the employee responsible for its filing.
6. Willful violations of these requirements are subject to criminal penalties (5 U.S.C. 552a(i)).

Place label between lines.  
Type information on label  
as shown.

SSN:      Name (Last, First, M.I.)      DOB:

NSN 7540-01-209-4939  
For Label Use:  
NSN 7530-00-577-4376 (cut sheet) or  
NSN 7530-00-082-2661 (marginally punched)

GPO : 1985 O 460-496 (22)



## Section F -Inpatient Medical Records.

### 1. Purpose and Background.

- a. Certain Coast Guard health care facilities have the capability and staffing to provide overnight care. Overnight care is defined as any period lasting more than four hours during which a beneficiary remains in the facility under the care or observation of a provider. By definition, overnight care may last less than 24 hours or it may last several days. Overnight care is utilized when a patient's condition or status requires observation, nursing care, frequent assessment, or other monitoring.
- b. Inpatient Medical Records (IMRs). Facilities providing overnight care shall create an Inpatient Medical Record (IMR) separate from the Health Record for the purpose of recording and preserving information related to the overnight care. The IMR shall be assembled as soon as a person is identified as needing overnight care. The IMR shall contain the following forms in a TOP TO BOTTOM sequence:
  - (1) Inpatient Medical Record Cover Sheet and Privacy Act Statement (Figure 4-F-1)
  - (2) SF-508, Doctor's Orders (most recent on top)
  - (3) SF-506, Clinical Record/Physical Exam
  - (4) SF-502, Narrative Summary
  - (5) SF-509, Doctor's Progress Notes (most recent on top)
  - (6) SF-511, Vital Signs Record
  - (7) SF-514, Laboratory Report Display
  - (8) SF-519, Radiologic Reports
  - (9) Patient Care Kardex
  - (10) Medication Kardex
  - (11) SF-513, Consultation sheet
  - (12) Miscellaneous forms (e.g., audiograms)
- c. Abbreviated Inpatient Medical Records (AIMRs). For patients who receive overnight care lasting 24 hours or less, an Abbreviated Inpatient Medical Record (AIMR) shall be created. The AIMR shall consist of at least an Inpatient Medical Record Cover Sheet, Privacy Act Statement, and an DD-2770, Abbreviated Medical Record form. SF-545, Laboratory Reports; SF-519, Radiologic Consultation Reports; Kardexes; and other forms may be included at the discretion of the clinic.



The AIMR shall be maintained while in use, completed, stored, and retired following the same requirements as listed for IMRs below.

- d. During the time that the patient is receiving care, the IMR may be maintained in a loose-leaf binder, clipboard, or other convenient device, at the facility's discretion. Devices should be chosen and maintained so that the privacy of the patient information contained therein is protected at all times. Keeping or storing the record at the patient's bedside is discouraged for privacy reasons.
  - e. Once the patient is released from overnight care, providers shall have 48 hours to complete their notations in the record (excluding dictated entries). All laboratory, radiologic and consultation forms shall also be included in the IMR within 48 hours of the patient's release from overnight care.
  - f. Dictated entries shall be entered in the medical record within 7 days of discharge. The record may be held in medical records and flagged as needing a dictated entry.
  - g. After all notations, lab reports, radiology reports and consultations have been entered into the IMR, the IMR forms shall be placed in a bifold paper jacket (form CG-3443-1), and secured via a two prong device. The medical records staff is responsible for ensuring that the documents are in the correct order and are stored properly.
2. Maintenance and Storage. IMRs are the property of the Federal Government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance concerning these acts is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). All requirements and directions for handling and storing IMRs also apply to AIMRs.
- a. Since IMRs contain personal information of an extremely critical or sensitive nature, they are considered to be Class III records requiring maximum security (high security locked cabinets or areas). IMRs shall be stored in well ventilated and sprinklered areas. Fire-resistant cabinets or containers shall be used for storage whenever possible.
  - b. IMRs shall be retained at the health care facility which created the record. IMRs will not be transferred with personnel who change duty stations. Copies of the IMR may be given to the individual if such a request is made in writing, or may be released to other persons, e.g., physicians or hospitals, if the patient requests or authorizes such release in writing. All release requests and authorizations will be inserted into the IMR cover.
  - c. IMRs will be retained at the creating health care facility for two (2) years after the date the patient is released from overnight care.
3. Disposition of IMRs. The IMR will be forwarded to the National Personnel Records Center (NPRC) as described in Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series), two years after the date the patient was released from



inpatient care. The NPRC requirements must be met in order for the NPRC to accept the records.

- a. Records must be sent in prescribed standard cubic foot cartons. Cartons are available from the General Services Administration Federal Supply Service (FSS). The FSS stock number is NSN 8115-00-117-8344. All non-standard cartons will be returned at the expense of the originating organization.
- b. NPRC does not accept accessions of less than one cubic foot. Small amounts shall be held until a volume of one cubic foot or more is reached.
- c. Print the accession number on each box, starting in the upper left hand corner (see Figure 4-F-2). Mark the front of the box only. The accession number consists of the RG, which is always 26 for the Coast Guard, the current FY in which the records are being shipped, and a four digit number assigned by NPRC (see 4-F-3.j. for SF-135 preparation). Mark the front of the box only. Ensure that the information printed on the box is not obscured in any way, and that removal of tape or other sealing materials will not remove vital information.
- d. Number each box consecutively, e.g., 1 of 8, 2 of 8, 3 of 8...8 of 8; or 1/8, 2/8, 3/8...8/8, in the upper right hand corner. See Figure 4-F-2 for placement.
- e. Records shall be arranged in each storage box either alphabetically or numerically. Print the identifier of the first and last record/folder that is contained in the box on the center front of each box as shown in Figure 4-F-2.
- f. Enclose in the first box of each accession one copy of the SF-135 and any alphabetical or numerical listing needed to reference the records.
- g. Ship records together so they arrive at the NPRC at the same time. Shipments of 10 cubic feet or more shall be palletized as shown in Figure 4-F-3.
- h. Records must be shipped within 90 days of being assigned an accession number. Failure to ship within 90 days will void the accession number.
- i. Each clinic that transfers IMRs to NPRC must keep a master list (hard copy) of the records sent. The master list must be retained at the clinic for a period of 50 years.
- j. All shipments to NPRC must be accompanied by SF-135, Records Transmittal and Receipt form. The transmittal form must include the name on the record and the individual's social security number. The accession number elements include the RG which is always 26 for the Coast Guard, the current FY during which the record is shipped, and the 4 digit sequential number assigned by NPRC. Also include the date sent. Complete SF-135 preparation and submission instructions are contained in the Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).



4. Inpatient Medical Record Forms and Required Entries.

a. SF-508, Doctor's Orders.

- (1) Purpose. SF-508 is used to record written and verbal orders of the medical or dental staff; record that nurses have noted orders; record automatic stop dates for medications and time limited treatments; and record the RN review of orders which shall be performed every 24 hours.
- (2) Preparation. (See Figure 4-F-4)
  - (a) When Prepared. SF-508 shall be used to communicate doctor's orders for all persons admitted to the medical facility inpatient area.
  - (b) Required Entries.
    - 1 Patient identification information may be written in or overprinted using a patient identification card.
    - 2 The date and time at which the order is written by the provider will be listed under the start column. If a verbal order is received, the date and time at which the order was received will be noted by the person who received the order in the start column. All verbal orders must be countersigned by the admitting provider on the next working day.
    - 3 Certain orders may be defined as time limited, e.g., complete bedrest for 24 hours, tilts q 8 hours X 3, etc. In addition, the facility shall define the length of time between renewal of orders for medications, treatments, etc. For orders which are time limited, the date and time when the order expires shall be noted under the stop column.
    - 4 All doctor's orders shall be listed on the form under drug orders. Orders shall be printed clearly in black ink. Only approved abbreviations shall be used. Nursing staff and/or health services technicians are required to contact the provider who wrote the order if there are any questions or difficulty encountered in reading the written order.

b. SF-506, Clinical Record/Physical Exam.

- (1) Purpose. SF-506 is part of the inpatient medical record. It is used to record information obtained from physical examinations.
- (2) Preparation. (See Figure 4-F-5)



- (a) When Prepared. SF-506 shall be prepared when a patient is admitted to the medical facility.
- (b) Required Entries.
  - 1 Patient identification information may be written in or printed using a patient identification card.
  - 2 Fill in the date that the exam is conducted in the upper left corner. The patient's self reported height may be used. Patients shall be weighed accurately on the day of admission and the weight entered as present weight. Vital signs to include temperature, pulse and blood pressure are recorded in the appropriate boxes. Rectal temperatures shall be identified by an "R" after the temperature reading. Axillary temperatures in adults are unreliable and will not be used.
  - 3 A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the treatment plan and interventions. Examination notations may be continued on the reverse of the form. If the back of the form is used, this must be indicated on the front of the form. The examiner will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.

c. SF-509, Progress Notes.

- (1) Purpose. SF-509 is part of the inpatient medical record. It is used to record the progress of the patient's condition, therapy or other treatment(s), as well as any other information relevant to the patient's condition or treatment such as laboratory tests and results.
- (2) Preparation. (See Figure 4-F-6)
  - (a) When Prepared. SF-509 shall be prepared when a patient is admitted to the medical facility inpatient area.
  - (b) Required Entries.
    - 1 Patient identification information may be written in or overprinted using a patient identification card.
    - 2 Fill in the left column with the date and time at which the entry is being created. Begin writing to the right of the solid brown line. Notes will be written in SOAP format (see 4-B-5.a.(4)). The person creating the note will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.



d. SF-511, Vital Signs Record.

(1) Purpose. SF-511 shall be used to document vital sign measurements, height, weight, hospital day and, if appropriate, postoperative day for patients admitted to the medical facility inpatient area.

(2) Preparation. (See Figure 4-F-7)

(a) When Prepared. SF-511 shall be prepared when a patient is admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Hospital day one shall be the day of admission.

3 If the patient undergoes an invasive procedure, "op" shall be written after the word post in the left column. The day of surgery shall be noted by writing "DOS" in the appropriate column. The day following the day of surgery is post-op day one. Post-op days shall be numbered consecutively thereafter.

4 The month in which the patient is admitted shall be written on the fifth line, first column. The year shall be completed by writing in the correct numerals after "19" on the fifth line.

5 The calendar date on which the patient is admitted shall be written in on the line next to the word day, e.g., if the patient is admitted on 3 June, the hospital day is one, and a "3" is written on the line next to the word day.

6 The hour at which the vital sign measurements are to be made are noted in the spaces next to the word hour. Use 24 hour clock notations, e.g., 11 p.m. is 2300, etc.

7 Once vital signs have been measured, they shall be recorded on the form using the symbols for pulse and temperature. Symbols are placed in the columns, not on the brown dotted lines.

8 Blood pressure measurements are written in the spaces to the right of the words "blood pressure". The first measurement made after midnight is written in the top left column, the second is written below it. The first measurement made after noon is written in the top box in the right side column, the second below that, etc. Blood pressure may also be represented by x marks placed at the systolic



and diastolic measurements corresponding to the scale for pulse measurements (see Figure 4-F-7).

- 9 Other vital signs measurements or intake and output measurements may be written in the spaces on the lower part of the form, or a local overprint/stamp may be used.
- 10 Both sides of the form will be used. If the second side of the form is used, the word "continued" will be clearly written on the bottom of the first page.

e. SF-514, Laboratory Reports.

- (1) Purpose. SF-514 is part of the inpatient medical record. It is used to keep laboratory report forms neat, in proper order, make them easily accessible to caregivers, and stores them as part of the inpatient medical record. SF-545, Clinical Record - Laboratory Report Display may be used in lieu of SF-514.
- (2) Preparation. (See Figure 4-B-12)
  - (a) When Prepared. SF-514/SF-545 shall be prepared when a patient is admitted to the inpatient medical area.
  - (b) Required Entries.
    - 1 Patient identification information may be written in or overprinted using a patient identification card.
    - 2 Reports (or chits) may be attached to the form using either the self adhesive on the back of the chit, or by neatly placing a strip of clear adhesive tape horizontally across the top of the report, so that the lower half of the tape strip is touching the chit and the upper half is sticking to the SF-514/SF-545.

f. SF-519, Radiologic Consultation Reports.

- (1) Purpose. SF-519 is part of the inpatient medical record. It is used to collect radiologic reports for easy access by caregivers and to store the reports with the inpatient medical record.
- (2) Preparation.
  - (a) When Prepared. SF-519 shall be prepared when a patient is admitted to the inpatient medical area.
  - (b) Required Entries. Reports shall be attached to the form using the self stick adhesive on the back of the report or clear adhesive tape. See 4-B-19.



g. DD-2770 (replaces SF 539) Abbreviated Medical Record.

- (1) Purpose. DD-2770 is used to record history, exam findings, patient progress, doctor's orders, vital signs, output, medications and nurse's notes for patients requiring overnight care who remain 24 hours or less.
- (2) Preparation. (See Figure 4-F-8)
  - (a) When Prepared. DD-2770 may be used for any overnight care patient for whom total stay is anticipated to be 24 hours or less. If length of stay exceeds 24 hours, a full IMR must be initiated to provide proper documentation of the patient's stay. The DD-2770 shall be prepared when a short stay patient is admitted to the inpatient medical area.
  - (b) Required Entries.
    - 1 Patient identification information may be written in or overprinted using a patient identification card.
    - 2 History, chief complaint, and condition on admission must be documented in the top box on page one. Date of admission shall be noted here also.
    - 3 Physical examination findings shall be noted in the center box on page one. Physical exam findings shall be completely noted and appropriate to the condition. Deferred exams, such as rectal exams, shall be noted as such.
    - 4 The patient's progress over the 24 hour period between admission and discharge will be noted by the medical officer in the third box on page one. Date of discharge and final diagnosis shall be noted here also.
    - 5 The physician shall sign the form in the box provided and use a printed ink stamp to clearly mark his/her name, rank, and SSN. The date the form is signed shall be written in the box provided next to the signature.
    - 6 The location of the clinic or dispensary, for example, Dispensary TRACEN Cape May, shall be written or stamped in the box marked organization.
    - 7 Doctor's orders shall be written only in the space provided on page two. Each order group written shall be dated and signed. A printed ink stamp shall be used by medical officers to mark name, rank, and SSN. All medical and dental orders given during the patient's stay must be recorded. A second page should be started if the number of orders exceeds space available on one page.



- 8 Vital sign measurements shall be recorded in the spaces provided with the date and time of each notation. Bowel movements and urine output are noted in the columns marked stools and weight.
- 9 Medications administered and brief notes regarding the patient's condition shall be made in the nurse's notes area. Medication name, dose, route, and time given shall be recorded for each dose of medication administered. Each notation shall be signed with the name, military rank, or title for civilians, e.g., RN or LPN, of the person making the note.



**FIGURE 4-F-1**

**INPATIENT MEDICAL RECORD COVER SHEET**

(See Privacy Act Statement on Reverse)

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Rank/Rate: \_\_\_\_\_  
Last, First, MI

Unit: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Religon: \_\_\_\_\_  
YY MM DD

Home Address: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
\_\_\_\_\_

Previous Admission: ☐ Yes ☐ No If yes, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
YY MM DD

Date of Present Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Hours  
YY MM DD

Provisional Diagnosis

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Provisional Diagnosis

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Date of Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Hours  
YY MM DD

**DISPOSITION**

Duty Status: ☐ FFD ☐ NFFD ☐ FFLD Restrictions: \_\_\_\_\_

Activity Restrictions: \_\_\_\_\_

Diet: \_\_\_\_\_

Medications: \_\_\_\_\_

Follow-up Appointment(s): \_\_\_\_\_

\_\_\_\_\_  
**Admitting Medical Officer**

\_\_\_\_\_  
**Discharging Medical Officer**

Time Unit Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Hours  
YY MM DD

Name of Staff Member Notifying: \_\_\_\_\_

Name of Person at Unit Receiving Call: \_\_\_\_\_  
Name and Rank/Rate



## FIGURE 4-F-1 (reverse)

### PRIVACY ACT STATEMENT

In accordance with 5 USC 552a (e)(3), the following applies to persons providing personal information to the U.S. Coast Guard.

1. Section 632, Title 14 USC, § 1071 – 1087. Title 10 USC, and Executive Order 9397 authorizes collection and application of this information.

2. The principal purpose for which this information is intended is to assist medical personnel in developing records to facilitate and document your health condition(s), in order to provide a complete account of care rendered, including diagnosis, treatment, and results. The social security number is necessary to identify the person and records. Family information is required for notification of next of kin in the unlikely event of an emergency.

3. The routine use of this information is for review by attending medical officers and for future reference in rendering health care.

4. Disclosure of this information is voluntary. However, failure to provide the requested information may result in an inability of the Coast Guard medical personnel to deliver comprehensive treatment.

**Please note the following and indicate your wishes:**

I DO / DO NOT GIVE PERMISSION FOR THE ATTENDING MEDICAL OFFICER AND THE DISPENSARY STAFF TO DISCUSS MY MEDICAL CONDITION OR THE SITUATION OF MY ADMISSION WITH MY PARENTS OR LEGAL GUARDIANS, UPON MY REQUEST.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

### PERSONNEL AUTHORIZED SEPARATE RATIONS

I understand that this facility provides three meals daily for all patients. Further, persons authorized to mess separately will be required to make repayments for meals consumed during their stay.

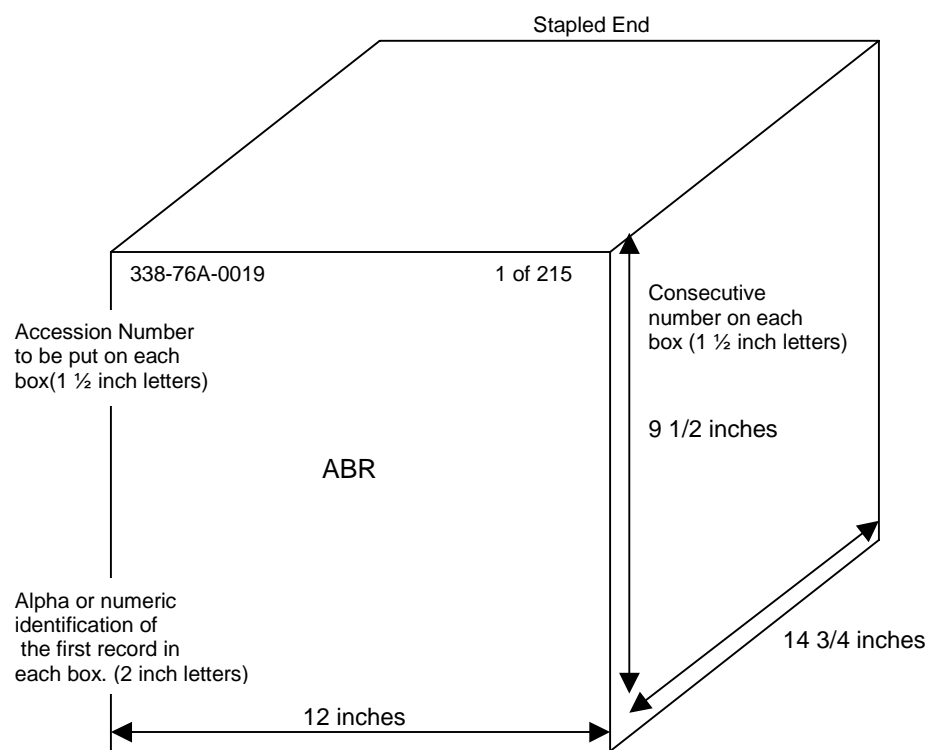
I have read and understand the statement about separate rations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



FIGURE 4-F-2





**FIGURE 4-F-3**

[illegible]



Figure 4-F-4

| INSTRUCTIONS   |      |    |   |                    |                   |
|--|------|----|---|--------------------|-------------------|
| NURSE: Retain a copy and send to Pharmacy after each order is written. |      |    |   |                    |                   |
| MEDICAL RECORD   |      |    | DOCTOR'S ORDERS<br><i>(Sign all orders)</i> |                    |                   |
| HOUR   |      | RX | DRUG ORDERS                                 | DOCTOR'S SIGNATURE | NURSE'S SIGNATURE |
| START  | STOP |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
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|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |
|  |      |    |   |                    |                   |

*If needed, continue on Page 2.*

|   |              |          |
|---|--------------|----------|
| PATIENT'S IDENTIFICATION<br><small>(For typed or written entries give: Name – last, first, middle; grade; rank; rate; hospital or medical facility)</small> | REGISTER NO. | WARD NO. |
|---|--------------|----------|

**DOCTOR'S ORDERS**  
  
**STANDARD FORM 508** (Rev. 10-7)  
Prescribed by GSA and ICMR  
 FPMR 101-11 806-8  
 508-110



FIGURE 4-F-5

Standard Form 506 (Rev 2-99)

AUTHORIZED FOR LOCAL REPRODUCTION

| Clinical Record |        | PHYSICAL EXAMINATION |         |         |             |       |                |
|-----------------|--------|----------------------|---------|---------|-------------|-------|----------------|
| Date of Exam    | Height | Weight               |         |         | Temperature | Pulse | Blood Pressure |
|                 |        | Average              | Maximum | Present |             |       |                |

Instructions: Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Breast; (11) Lungs; (12) Cardiovascular; (13) Abdomen; (14) Hernia; (15) Genitalia; (16) Pelvic; (17) Rectal; (18) Prostate; (19) Back; (20) Extremities; (21) Neurological; (22) Skin; (23) Lymphatics.

SAMPLE FORM

(Continue reverses side)

|  |                              |       |                       |                                       |         |
|--|------------------------------|-------|-----------------------|---------------------------------------|---------|
| RELATIONSHIP TO SPONSOR  | SPONSOR'S NAME               |       |                       | SPONSOR'S ID NUMBER<br>(SSN or Other) |         |
|  | LAST                         | First | MI                    |                                       |         |
| DEPART./SERVICE  | HOSPITAL OR MEDICAL FACILITY |       | RECORDS MAINTAINED AT |                                       |         |
| PATIENT'S IDENTIFICATION (For typed or written entries give: Name-Last First, Middle; grade; date; hospital or medical facility) |                              |       |                       | REGISTER NO                           | WARD NO |

PHYSICAL EXAMINATION RECORD  
Standard Form 506 (Rev 2-99)  
Prescribed by GSA/ICMR (41 CFR) 101-11 .203(b)(10)



Figure 4-F-5 (Reverse)

|                      |            |                |           |
|----------------------|------------|----------------|-----------|
| SF 506 (Rev 2-99)    |            |                |           |
| LAST NAME            | FIRST NAME | MIDDLE INITIAL | ID NUMBER |
| PHYSICAL EXAMINATION |            |                |           |

SAMPLE FORM

|                        |                   |
|------------------------|-------------------|
| INITIAL IMPRESSION     |                   |
| SIGNATURE OF PHYSICIAN | NAME OF PHYSICIAN |

Standard Form 506 (Rev. 2-99) BACK



**SAMPLE FORM**

**PROGRESS NOTES**  
**MEDICAL RECORD**  
**STANDARD FORM 509 (REV-7-91) EG**  
 Prescribed by GSA/ICMR (41 CFR) 201-9.202-1  
 Designed using Perform Pro. WHS/DIOR, Jul94



Figure 4-F-7

| MEDICAL RECORD |                |  |  | VITAL SIGNS RECORD |  |  |  |  |  |  |  |  |  |         |  |
|----------------|----------------|--|--|--------------------|--|--|--|--|--|--|--|--|--|---------|--|
| HOSPITAL DAY   |                |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |
| POST-          | DAY            |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |
| MONTH-YEAR     | DAY            |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |
| 19             | HOUR           |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |
| PULSE<br>(C)   | TEMP. F<br>(°) |  |  |                    |  |  |  |  |  |  |  |  |  | TEMP. C |  |
|                | 105°           |  |  |                    |  |  |  |  |  |  |  |  |  | 40.6°   |  |
| 180            | 104°           |  |  |                    |  |  |  |  |  |  |  |  |  | 40.0°   |  |
| 170            | 103°           |  |  |                    |  |  |  |  |  |  |  |  |  | 39.4°   |  |
| 160            | 102°           |  |  |                    |  |  |  |  |  |  |  |  |  | 38.9°   |  |
| 150            | 101°           |  |  |                    |  |  |  |  |  |  |  |  |  | 38.3°   |  |
| 140            | 100°           |  |  |                    |  |  |  |  |  |  |  |  |  | 37.8°   |  |
| 130            | 99°            |  |  |                    |  |  |  |  |  |  |  |  |  | 37.2°   |  |
|                | 98.6°          |  |  |                    |  |  |  |  |  |  |  |  |  | 36.0°   |  |
| 120            | 98°            |  |  |                    |  |  |  |  |  |  |  |  |  | 36.7°   |  |
| 110            | 97°            |  |  |                    |  |  |  |  |  |  |  |  |  | 36.1°   |  |
| 100            | 96°            |  |  |                    |  |  |  |  |  |  |  |  |  | 35.6°   |  |
| 90             | 95°            |  |  |                    |  |  |  |  |  |  |  |  |  | 35.0°   |  |
| 80             |                |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |
| 70             |                |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |
| 60             |                |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |
| 50             |                |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |
| 40             |                |  |  |                    |  |  |  |  |  |  |  |  |  |         |  |

**RESPIRATION RECORD**

|  |                |        |  |  |  |  |  |  |  |  |  |  |  |  |
|--|----------------|--------|--|--|--|--|--|--|--|--|--|--|--|--|
| Record special data only when so ordered | BLOOD PRESSURE |        |  |  |  |  |  |  |  |  |  |  |  |  |
|  | HEIGHT:        | WEIGHT |  |  |  |  |  |  |  |  |  |  |  |  |
|  |                |        |  |  |  |  |  |  |  |  |  |  |  |  |
|  |                |        |  |  |  |  |  |  |  |  |  |  |  |  |
|  |                |        |  |  |  |  |  |  |  |  |  |  |  |  |

(Centigrade Equivalents, for Reference only)

**PATIENT'S IDENTIFICATION** (For typed or written entries give: Name - last, first, middle; rank, rate, hospital or medical facility)

REGISTER NO.

WARD NO.

**VITAL SIGNS RECORD**

STANDARD FORM 511 (Rev. 9-79)  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-45.505



FIGURE 4-F-8

|   |          |          |  |
|---|----------|----------|--|
| <b>ABBREVIATED MEDICAL RECORD</b>   |          |          | 1. ADMISSION DATE(yyymmdd)                         |
| 2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW  |          |          |  |
| 3. PHYSICAL EXAMINATION <i>(Including pertinent positives and negatives)</i>  |          |          |  |
| 4. IMPRESSION <i>(enter admission note with plan on progress notes)</i>   |          |          |  |
| 5. ADMITTING OFFICER  |          |          |  |
| a. SIGNATURE  |          |          | b. DATE SIGNED (YYYYMMDD)                          |
| 6. DISCHARGE NOTE <i>(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)</i> |          |          | 7. DISCHARGE DATE (YYYYMMDD)                       |
| 8. DISCHARGE OFFICER  |          |          |  |
| a. NAME <i>(Last, First, Middle Initial)</i>  | b. GRADE | c. TITLE | d. SIGNATURE                                       |
| 9. PATIENT IDENTIFICATION <i>(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)</i>                        |          |          | 10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:        |
|   |          |          | 11. COPY PLACED IN OUTPATIENT RECORD (x WHEN DONE) |

DD FORM 2770, APR 1998 (EG) Replaces SF 509



## Section G – Mental Health Records.

1. Active duty: Complete mental health assessments and visits will be done in an IMB, DMB or traditional psychiatric evaluation format and recorded on SF-600, SF-513, IMB, DMB, or typed psychiatric evaluation forms as appropriate. Active duty episodic visits and routine appointments will be recorded on SF-600 in SOAP format. The Objective (“O”) section would include mental status observations and any other pertinent physical findings. Records of active duty mental health assessments and visits will be kept in the main health record (CG-3443). An additional separate mental health record may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner’s office. New patients would be evaluated IAW traditional psychiatric evaluation.
2. Non- Active duty: Separate records of mental health care may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner’s office. Alternatively, the mental health practitioner may elect to keep records of visits in the dependent or retiree’s main based record (CG-3443-1). Should the practitioner elect to maintain a separate office based record for non-active duty patients, the main health record (orange jacket) must include, at a minimum, the diagnosis in the problem summary listing, current psychiatric medications on the SF-600, and lab work ordered by the mental health provider. New patients would be evaluated IAW traditional psychiatric evaluation. Episodic and follow up visits would be recorded in a SOAP format.
3. Psychiatric evaluation format: The psychiatric evaluation shall include, at a minimum: patient information, chief complaint, history of present illness, past history (psychiatric symptoms, diagnoses, and care medical illness, surgeries, current medications, allergies, alcohol & drug history), personal history, family history, mental status exam, assessment (DSM-IV), prognosis, and plan. Included in all assessments and other visits as appropriate will be an estimation of potential for harm to self or others. In addition, notes should contain sufficient information to establish that the criteria for any new DSM based diagnosis are met.
4. Custody of Mental Health Records: Records kept in the mental health practitioner’s office are property of the CG and copies should be available to other civilian practitioners or agencies at the patient’s request. These records should also be available to other CG providers, as part of an official records review process, and as directed in Section 4.A.5. of this Manual.



## CHAPTER 5

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## CHAPTER 5. DEATHS AND PSYCHIATRIC CONDITIONS (PERSONALITY)

### Section A - Deaths.

1. General. Chapter 11 of the Personnel Manual, COMDTINST M1000.6(series) contains further guidance concerning casualties and decedent affairs.
2. Duties of Medical Officers or Health Services Department Representatives in the Event of A Death at A Coast Guard Unit. The medical officer or health services department representative shall report immediately to the scene and:
  - a. advise the commanding officer of the name, grade or rate, and social security number of the decedent;
  - b. advise the commanding officer of the time and place of death;
  - c. advise the commanding officer, insofar as possible, as to the cause of death;
  - d. ensure notification of the quarantine officer or coroner if required; and
  - e. arrange with local civilian authorities for issuing a death certificate.
3. Determining Cause of Death. When an active duty Coast Guard member dies aboard a Coast Guard vessel or station under unnatural or suspicious circumstances, or when the cause of death is unknown, an administrative investigation shall immediately be convened in accordance with Section 11-A-3 of the Personnel Manual, COMDTINST M1000.6(series) and Chapter 5 of the Administrative Investigations Manual, COMDTINST M5830.1 (series).
4. Death Certificates for Deaths Occurring Away From Command or in Foreign Ports.
  - f. When an active duty member dies while away from his/her duty station, the commanding officer or designated representative shall obtain a death certificate from civilian authorities. If the civilian death certificate does not furnish all necessary information, the district commander of the district in which the death occurred shall request additional information.
  - g. If death occurs abroad, request the nearest United States Consular Office to obtain a death certificate from civilian authorities.
  - h. When an active duty member, or a Reserve performing inactive duty for training, is in a missing status because of events in international waters and no identifiable remains can be recovered, and no civilian death certificate is issued, a report (including recommendations) shall be made as per Section 11-A, Personnel Manual, COMDTINST M1000.6 (series).
5. Relations with Civilian Authorities. When a Coast Guard member dies outside the limits of a Coast Guard reservation, the body shall not be moved until permission has been obtained from civilian authorities (e.g., coroner's office and/or medical examiner). In



order that there may be full understanding and accord between the Coast Guard and civilian authorities, appropriate procedures will be developed for each command area, in consultation with the civilian authorities, covering deaths of personnel within and without the limits of Coast Guard commands. In general, and except where the state has retained concurrent jurisdiction with the United States, civilian authorities have no jurisdiction over deaths occurring on Coast Guard reservations. A transit or burial permit, however, issued by civilian authorities is required for removal of a body from a Coast Guard reservation for shipment or burial.

6. Reporting Deaths to Civilian Authorities. When a death occurs at a Coast Guard activity in any state, territory, or insular possession of the United States, the death must be reported promptly to civilian authorities. Local agreements concerning reporting and preparing death certificates shall be made between the commanding officer, or designated representative, and the civilian authorities.
7. Death Forms for Civilian Agencies and Individuals. Forward all requests for completing blank forms concerning death of Coast Guard personnel to Commandant (G-WP) for action.
8. Identification of Remains. Identification of remains may be established by marks and scars, dental records, fingerprints, and personal recognition. In questionable cases, a dental officer shall examine the remains and record observations on a SF-603 for comparison with other available records.



Section B - Psychiatric Conditions (including personality disorders).

1. General. The following diagnostic categories conform to DSM IV-R and indicate the appropriate reference for disposition. In determining qualification for appointment, enlistment, and induction, or appropriate disposition (when the condition has been determined to be disqualifying for retention in accordance with paragraph 3-F-16), the diagnosis appears under DSM IV Axis I or Axis II. Conditions generally considered treatable and not grounds for immediate separation, mental health treatment may be authorized for members when medically necessary to relieve suffering and/or maintain fitness for unrestricted duty. The decision to provide treatment for mental health conditions will be based on a review of all factors, including the opinion of experts, probability of a successful outcome, and the presence of other physical or mental conditions.
  - a. If a successful outcome (availability for worldwide assignment) is not realized within six months of the initiation of therapy, the patient's condition must be reassessed. If the reassessment indicates that the prognosis for a successful outcome is poor, the member shall be processed for discharge pursuant to Chapter 12 of the Personnel Manual or through the Physical Disability Evaluation System (PHYSICAL DISABILITY EVALUATION SYSTEM).
2. Personality Disorders. These disorders are disqualifying for appointment, enlistment, and induction under Section 3-D-33 herein or shall be processed in accordance with Chapter 12, Personnel Manual, COMDTINST M1000.6 (series). These are coded on Axis II.
  - a. 301.00 Paranoid.
  - b. 301.20 Schizoid.
  - c. 301.22 Schizotypal.
  - d. 301.4 Obsessive compulsive.
  - e. 301.50 Histrionic.
  - f. 301.6 Dependent.
  - g. 301.7 Antisocial.
  - h. 301.81 Narcissistic.
  - i. 301.82 Avoidant.
  - j. 301.83 Borderline.
  - k. 301.9 Personality disorder NOS (includes Passive-aggressive).



1. Personality trait(s) considered unfitting per paragraph 3-F-16.c.
3. Adjustment Disorders. These disorders are generally treatable and not usually grounds for separation. However, when these conditions persist or treatment is likely to be prolonged or non-curative, (e.g., inability to adjust to military life/sea duty, separation from family/friends) process in accordance with Chapter 12, Personnel Manual, COMDTINST M1000.6 (series) is necessary.
  - a. 309.0 With depressed mood.
  - b. 309.24 With anxiety.
  - c. 309.28 With mixed anxiety and depressed moods.
  - d. 309.3 With disturbance of conduct.
  - e. 309.4 With mixed disturbance of emotions and conduct.
  - f. 309.90 Adjustment disorder unspecified.
4. Organic Mental Disorders. These disorders are either disqualifying for appointment, enlistment, and induction under Section 3-D-29 of this manual or shall be processed in accordance with Physical Disability Evaluation System (PHYSICAL DISABILITY EVALUATION SYSTEM), COMDTINST M1850.2 (series).
  - a. Dementias arising in the senium and presenium.
    - (1) Dementia of the Alzheimer type, with early onset.
      - (a) 290.00 Uncomplicated.
      - (b) 290.11 With delirium.
      - (c) 290.12 With delusions.
      - (d) 290.13 With depressed mood.
    - (2) 290.4 Vascular Dementia (various subtypes).
    - (3) 294.x Dementia due to other medical conditions (various subtypes).
    - (4) 294.8 Dementia NOS.
  - b. Other Organic Mental Disorders associated with Axis III physical disorders or conditions, or etiology is unknown, including but not limited to the following.
    - (5) 293.0 Delirium due to general medical condition.
    - (6) 293.81 Psychotic disorder with delusions due to a general medical condition.
    - (7) 293.82 Psychotic disorder with hallucinosis due to a general medical condition.
    - (8) 293.83 Mood disorder due to a general medical condition.



- (9) 294.00 Amnestic disorder due to general medical condition.
- (10) 310.1 Personality change due to a general medical condition.
- 5. Psychoactive Substance Use Disorders. These disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-35 of this manual or shall be processed in accordance with Chapter 20, Personnel Manual, COMDTINST M1000.6 (series).
  - a. 303.90 Alcohol dependence (alcoholism).
  - b. 304.00 Opioid dependence.
  - c. 304.10 Sedative, hypnotic, or anxiolytic dependence.
  - d. 304.20 Cocaine dependence.
  - e. 304.30 Cannabis dependence.
  - f. 304.40 Amphetamine dependence.
  - g. 304.50 Hallucinogen dependence.
  - h. 304.60 Inhalant dependence.
  - i. 304.90 Other (or unknown) substance, including PCP dependence.
  - j. 305.00 Alcohol abuse.
  - k. 305.20 Cannabis abuse.
  - l. 305.30 Hallucinogen abuse.
  - m. 305.40 Sedative, hypnotic, or anxiolytic abuse.
  - n. 305.50 Opioid abuse.
  - o. 305.60 Cocaine abuse.
  - p. 305.70 Amphetamine abuse.
  - q. 305.90 Other (or unknown) Substance abuse, including inhalant and PCP abuse.
- 6. Schizophrenia. These disorders are disqualifying under Section 3-D-30 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).
  - a. 295.10 Disorganized type.
  - b. 295.20 Catatonic type.



- c. 295.30 Paranoid type.
- d. 295.60 Residual type.
- e. 295.90 Undifferentiated type.
- 7. Psychotic Disorders Not Elsewhere Classified. These disorders are disqualifying under Section 3-D-30 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).
  - a. 295.40 Schizophreniform disorder.
  - b. 295.70 Schizoaffective disorder.
  - c. 297.30 Induced psychotic disorder.
  - d. 298.80 Brief psychotic disorder.
  - e. 298.90 Psychotic disorder NOS.
- 8. Delusional (Paranoid) Disorder. 297.1, Delusional (Paranoid) Disorder, is disqualifying under Section 3-D-30 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).
- 9. Neurotic Disorders. These disorders are now included in Anxiety, Somatoform, Dissociative, and Sexual Disorders.
- 10. Mood Disorders. These disorders are disqualifying for enlistment under Section 3-D-31 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).
  - a. Bipolar I Disorders.
    - (1) 296.0X Bipolar I disorder, single manic episode (various subtypes).
    - (2) 296.40 Bipolar I disorder, most recent episode hypomanic.
    - (3) 296.4X Bipolar I disorder, most recent episode manic (various sub-types).
    - (4) 296.5X Bipolar I disorder, most recent depressed (various sub-types).
    - (5) 296.6X Bipolar I disorder, most recent episode mixed, (various sub-types).
    - (6) 296.7 Bipolar I disorder, most recent episode unspecified.
    - (7) 296.89 Bipolar II disorder.
    - (8) 301.13 Cyclothymia.
  - b. Depressive Disorders.
    - (1) 296.XX Major depressive disorder (various sub-types).
    - (2) 300.4 Dysthymic disorder (or depressive neurosis).



- (3) 311 Depressive disorder NOS.
- 11. Anxiety Disorders (or Anxiety and Phobic Neuroses). These disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-32 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series) except as noted on (5) below.
  - a. Panic Disorders.
    - (1) 300.01 Without agoraphobia.
    - (2) 300.21 With agoraphobia.
    - (3) 300.22 Agoraphobia without history of panic disorder.
    - (4) 300.23 Social phobia.
    - (5) 300.29 Specific phobia. [Chapter 12, Personnel Manual, COMDTINST M1000.6 (series).]
  - b. Other Anxiety disorders.
    - (1) 300.00 Anxiety disorder NOS.
    - (2) 300.02 Generalized anxiety disorder.
    - (3) 300.3 Obsessive-compulsive disorder (or obsessive compulsive neurosis).
    - (4) 309.81 Post-traumatic stress disorder.
- 12. Somatoform Disorders. These disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-32 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).
  - a. 300.11 Conversion disorder.
  - b. 300.70 Hypochondriasis (or hypochondrical neurosis). Body Dysmorphic disorder. Somatoform disorder NOS.
  - c. 300.81 Somatization disorder or undifferentiated somatoform disorder.
  - d. 307.80 Pain disorder associated with psychological factors.
- 13. Dissociative Disorders (or Hysterical Neuroses, Dissociative Type). These disorders are disqualifying for appointment, enlistment, or enlistment under Section 3-D-32 of this manual or shall be processed in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).
  - a. 300.12 Dissociative amnesia.
  - b. 300.13 Dissociative fugue.
  - c. 300.14 Dissociative identity disorder.



- d. 300.15 Dissociative disorder NOS.
- e. 300.6 Depersonalization disorder.
- 14. Sexual Disorders. These disorders are processed in accordance with Chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series).
  - a. Gender Identity Disorders.
    - (1) 302.6 Gender identity disorder in children (history of) or NOS.
    - (2) 302.85 Gender identity disorder in adolescents or adults.
  - b. Paraphilias.
    - (1) 302.2 Pedophilia.
    - (2) 302.3 Transvestic fetishism.
    - (3) 302.4 Exhibitionism.
    - (4) 302.81 Fetishism.
    - (5) 302.82 Voyeurism.
    - (6) 302.83 Sexual masochism.
    - (7) 302.84 Sexual sadism.
    - (8) 302.89 Frotteurism.
    - (9) 302.9 Paraphilia NOS (includes Zoophilia).
- 15. Sexual Dysfunctions. These are not grounds for action as they have no direct bearing upon fitness for duty.
  - a. 302.70 Sexual dysfunction NOS.
  - b. 302.71 Hypoactive sexual desire.
  - c. 302.72 Female arousal disorder. Male erectile disorder.
  - d. 302.73 Female orgasmic disorder.
  - e. 302.74 Male orgasmic disorder.
  - f. 302.75 Premature ejaculation.
  - g. 302.76 Dyspareunia.
  - h. 302.79 Sexual aversion disorder.
  - i. 302.9 Sexual Disorder NOS.
  - j. 306.51 Vaginismus.



16. Factitious Disorders. These disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-32 of this manual or should be processed in accordance with Chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series).
- a. 300.16 With predominantly psychological symptoms.
  - b. 300.19 Factitious disorder NOS.
  - c. 301.51 With predominantly physical symptoms, or combined.
17. Disorders of Impulse Control Not Elsewhere Classified. These disorders are disqualifying for enlistment under Section 3-D-33 of this manual or should be processed in accordance with Chapter 12 of the Personnel Manual COMDTINST M1000.6 (series).
- a. 312.30 Impulse control disorder NOS.
  - b. 312.31 Pathological gambling.
  - c. 312.32 Kleptomania.
  - d. 312.33 Pyromania.
  - e. 312.34 Intermittent explosive disorder.
  - f. 312.39 Trichotillomania.
18. Disorders Usually First Evident in Infancy, Childhood, or Adolescence. Except as indicated in parentheses, these disorders are disqualifying for appointment, enlistment, or induction under Section 3-D-33 of this manual, or shall be processed in accordance with Chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series), if the condition significantly impacts, or has the potential to significantly impact performance of duties (health, mission, and safety).
- a. Mental Retardation (Note: these are coded on Axis II).
    - (1) 317 Mild mental retardation, IQ 50-70.
    - (2) 318.X Moderate, severe, or profound mental retardation, IQ 35-49.
    - (3) 319 Mental retardation, severity unspecified.
  - b. Disruptive Behavior Disorders.
    - (1) 314.0X Attention deficit hyperactivity disorder (various types).
    - (2) 312.8 Conduct disorder.
    - (3) 312.9 Disruptive behavior disorder or attention deficit disorder, NOS.
    - (4) 313.81 Oppositional defiant disorder.
  - c. Other Disorders of Infancy, Childhood, or Adolescence.



- (1) 307.30 Stereotypic movement disorder.
  - (2) 309.21 Separation anxiety disorder.
  - (3) 313.23 Selective mutism.
  - (4) 313.82 Identity problem.
  - (5) 313.89 Reactive attachment disorder of infancy or early childhood.
- d. Eating Disorders. Eating disorders have a potential to affect fitness for duty, but the diagnosis of an eating disorder does not automatically mean the member is unsuitable for continued service. Individuals suspected of having an eating disorder shall be referred for evaluation by an Armed Forces psychiatrist or Armed Forces clinical psychologist. Treatment may be authorized in accordance with the same criteria as other mental conditions. See paragraph 5.B.1 of this Manual.
- (1) 307.1 Anorexia nervosa. (Shall be processed through Physical Disability Evaluation System (COMDTINST M1850.2 ))
  - (2) 307.50 Eating disorder NOS. Shall be processed in accordance with Chapter 12.B.12 or 12.A.15.h (as applicable) of the Personnel Manual, COMDTINST M1000.6(series), if the condition significantly impacts or has the potential to significantly impact performance of duties (health, mission, and safety).
  - (3) 307.51 Bulimia nervosa. (Shall be processed through Physical Disability Evaluation System (COMDTINST M1850.2))
  - (4) 307.52 Pica.
  - (5) 307.53 Rumination disorder.
- e. Tic Disorders.
- (1) 307.20 Tic disorder NOS.
  - (2) 307.21 Transient tic disorder.
  - (3) 307.22 Chronic motor or vocal tic disorder.
  - (4) 307.23 Tourette's disorder.
- f. Communication Disorder.
- (1) 307.0 Stuttering.
  - (2) 315.31 Expressive or mixed (expressive-receptive) language disorder.
  - (3) 315.39 Phonological disorder.
- g. Elimination Disorders.
- (1) 307.46 Sleepwalking disorder.
  - (2) 307.46 Sleep terror disorder.
  - (3) 307.6 Enuresis (not due to a general medical condition).



- (4) 307.7 Encopresis (without constipation and overflow incontinence.)
- h. Pervasive Developmental Disorder.
  - (1) 299.00 Autistic disorder.
  - (2) 299.80 Pervasive developmental disorder NOS.
- i. Specific Learning Developmental Disorders - (Note: These Are Coded on Axis II).
  - (1) 315.00 Reading disorder.
  - (2) 315.1 Mathematics disorder.
  - (3) 315.2 Disorder of written expression.
  - (4) 315.4 Developmental coordination disorder.
  - (5) 315.9 Learning disorder NOS.
- 19. 316.00 Psychological Factors Affecting Physical Condition. This disorder is not generally grounds for action alone. The physical condition must be specified on Axis III and will determine fitness.
- 20. V Codes for Conditions Not Attributable to a Mental Disorder that are a Focus of Attention or Treatment. These disorders are generally not of such severity as to lead to disqualification for enlistment or to separation. Where separation is indicated, process in accordance with Chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series).
  - a. V15.81 Noncompliance with medical treatment.
  - b. V61.1 Partner relational problem.
  - c. V61.20 Parent-child relational problem.
  - d. V61.8 Sibling relational problem.
  - e. V62.2 Occupational problem.
  - f. V62.3 Academic problem.
  - g. V62.81 Relational problem NOS.
  - h. V62.82 Bereavement.
  - i. V62.89 Borderline intellectual functioning.
  - j. V62.89 Phase of life problem or religious or spiritual problem.
  - k. V65.2 Malingering. (May be grounds for legal, administrative, or medical board proceedings in accordance with Section 2-A-4 of this manual depending on the circumstances)



- l. V71.01 Adult antisocial behavior.
  - m. V71.02 Child or adolescent antisocial behavior.
21. Additional Codes. These are nondiagnostic codes for administrative use and require no action.
- a. V71.09 No diagnosis or condition on Axis I.
  - b. V71.09 No diagnosis on Axis II.
  - c. 300.9 Unspecified mental disorder (nonpsychotic).
  - d. 799.9 Diagnosis or condition deferred on Axis I.
  - e. 799.9 Diagnosis deferred on Axis II.



Section C - Command directed Mental Health Evaluation of Coast Guard Service members.

1. General. A commander, (including commanding officers, of clinics) shall refer a Service member for an emergency mental health evaluation as soon as is practicable whenever a Service member indicates an intent to cause serious injury to himself or others, and the commander believes that the Service member may be suffering from a mental disorder.
  - a. Active Duty Mental Health Conditions and Emergencies, COMDTPUB P6520.1 refers to Public Law 102-484, Section 546, also known as the “Boxer Amendment” The Coast Guard is not included and therefore not subject to the Boxer’s Amendment. These restrictions are intended to prevent the unwarranted mental health evaluations or involuntary hospitalization as a form of harassment or retaliation.
  - b. Prior to transporting a Service member for an emergency evaluation, or shortly thereafter if the time and nature of the emergency does not permit, the commanding officer shall consult directly with a mental health care provider (or other health care provider if a mental health care provider is not available) at the MTF. The purpose of this consult is to communicate the observations and circumstances which led the commander to believe that the Service member’s behavior constituted an emergency. The commander will then forward to the mental health care provider consulted a memorandum documenting the information discussed.
2. When not an emergency, commanding officers suspecting a mental health evaluation may be indicated will:
  - a. Contact the appropriate point of contact at the servicing Coast Guard Medical clinic and speak directly with the point of contact to request a command-directed mental health evaluation. Signs of mental illness can include changes in behavior, mood, or thinking that interfere with normal functioning. The health care provider will clarify the request, urgency of the referral, and schedule an appointment.
  - b. Provide a memorandum from the commanding officer to the DoD MTF/clinic commander documenting this contact, subject: Command Referral for Mental Health Evaluation of (Service Member Rank, Name, Branch of Service and SSN. (sample letter Figure 1).
  - c. Counsel the Service member and insure that the Service member is provided written notice of the referral. A sample memorandum from the commanding officer to the MTF/clinic commander documenting this contact, subject: Notification of Commanding Officer Referral for Mental Health Evaluation (Non-Emergency). The notice will include the following: (sample letter Figure 2)
    - (1) Date and time the mental-health evaluation is scheduled.
    - (2) A brief, factual description of the Service member’s behavior and verbal expressions that indicate a mental-health evaluation is necessary.



- (3) Names of mental-health professionals the commander has consulted before making the referral. If consultation is not possible, commanders must include the reasons in the notice.
- d. Request the Service member sign the notice to report for a mental- health evaluation. If the Service member refuses to sign, the commander will note this response in the notice.
- e. Provide an escort to Service member referred for a mental- health evaluation.
- 3. Commanders shall provide a copy of the following rights to Service members who are referred:
  - a. A Service member has the right to obtain a second opinion at his own expense. The evaluation should be conducted within a reasonable period of time, usually within 10 days and will not delay nor substitute for an evaluation performed by a DoD mental health care.
  - b. No person may restrict the Service member from communicating with an attorney, IG, chaplain, Member of Congress, or other appropriate party about the member's referral.
  - c. Other than emergencies, the Service member will have at least 2 workdays before a scheduled mental-health evaluation to meet with an attorney, chaplain, IG, or other appropriate party. If a commander has reason to believe the condition of the Service member requires an immediate mental-health evaluation, the commander will state the reasons in writing as part of the request for evaluation.
  - d. If military duties prevent the Service member from complying with this policy, the commander seeking the referral will state the reasons in a memorandum.
- 4. No one will:
  - a. Refer a Service member for a mental-health evaluation as a reprisal for making or preparing a lawful communication to a Member of Congress, an authority in the Service member's chain of command, an IG, or a member of a DoD audit, inspection, investigation, or law enforcement organization.
  - b. Restrict a Service member from lawfully communicating with an IG, attorney, Member of Congress, or others about the Service member's referral for a mental-health evaluation.
  - c. These policies are not designed to limit the commander's authority to refer Service members for emergency mental-health evaluations and treatment when circumstances suggest the need for such action.



5. The specific procedures required by these regulations apply to mental health evaluations directed by a service member's commander as an exercise of the commander's discretionary authority. Evaluations NOT covered by these procedures include:
  - a. Voluntary self-referrals;
  - b. Criminal responsibility and competency inquiries conducted under Rule for Court-Martial 706 of the Manual for Courts-Martial;
  - c. Interviews conducted according to the Family Advocacy Program;
  - d. Referrals to the Alcohol and Drug Abuse Prevention and Control Program;
  - e. Security clearances.
  - f. Diagnostic referrals from other health care providers not part of the Service member's chain of command when the Service member consents to the evaluation; and;
  - g. Referrals for evaluations expressly required by regulation, without any discretion by the Service member's commander, such as enlisted administrative separations.
6. Procedures for using the memorandum requesting a mental health evaluation in emergency situations Commanders will:
  - a. When completing the memorandum Commanders should include as many details as possible.
  - b. Make one copy to give to the Service member.
  - c. Ensure that the Service member's escort hand carries the memorandum to the treatment facility. The memorandum will not be hand carried by the Service member being referred. This memorandum will not be sent through distribution channels, nor will it become part of the Service member's health record. The memorandum will be filed in the Department of Psychiatry of the medical treatment facility where the Service member was evaluated.



## FIGURE 1

Sample: Commanding Officer request for routine (non emergency) Mental Health Evaluation

Date:

Memorandum for Commanding Officer (Name of Medical Treatment Facility (MTF) or Clinic)

From: Commanding Officer, (Name of Command)

Subject: Command Referral for Mental Health Evaluation of (Service Member Rank, Name, Branch of Service and SSN)

Reference (a) Medical Manual COMDTINST M6000.1B, Chap 5-C

(b) Active Duty Mental Health Conditions and Emergencies, COMDTPUB P6520.1

1. In accordance with references (), I hereby request a formal mental health evaluation of (rank and name of Service member).
2. (Name and rank of Service member) has (years) and (months) active duty service and has been assigned to my command since (date). Armed Services Vocational Aptitude Battery (ASVAB) scores upon enlistment were: (list scores). Past average performance marks have ranged from \_\_\_\_\_ to \_\_\_\_\_ (give numerical scores). Legal action is/is not currently pending against the Service member. (If charges are pending, list dates and UCMJ articles). Past legal actions include: (List dates, charges, non judicial punishments (NJPs) and/or findings of Courts Martial.)
3. I have forwarded to the Service member a memorandum that advises (rank and name of Service member) of his (or her) rights. This memorandum also states the reasons for this referral, the name of the mental health care provider(s) with whom I consulted. A copy of this memorandum is attached for your review.
4. (Service member's rank and name) has been scheduled for evaluation by (name and rank of metal healthcare provider) at (name of MTF or clinic) on (date) at (time).
5. Should you wish additional information, you may contact (name and rank of the designated point of contact) at (telephone number).
6. Please provide a summary of your findings and recommendations to me as soon as they are available.

(Signature)

Rank and Name of Commanding Officer

Attachment:

As stated



## FIGURE 2

Sample: Service member notification of Commanding Officer referral for Mental Health Evaluation.

Date:

Memorandum for (Service member's rank, name and SSN)

From: Commanding Officer, (Name of Command)

Subject: Notification of Commanding Officer referral for Mental Health Evaluation (non emergency).

References: (a) Medical Manual COMDTINST M6000.1B, Chap 5-C  
(b) Active Duty Mental Health Conditions and Emergencies, COMDTPUB P6520.1

1. In accordance with references (), this memorandum is to inform you that I am referring you for a mental health evaluation.
2. The following is a description of your behaviors and/or verbal expressions that I considered in determining the need for a mental health evaluation: (Provide dates and a brief factual description of the Service member's actions of concern.)
3. Before making this referral, I consulted with the following mental health care provider(s) about your recent actions: (list rank, name, corps, branch of each provider consulted) at (name of Medical Treatment Facility (MTF) or clinic) on (date(s)). (Rank(s) and name(s) of mental healthcare provider(s)) concur(s) that this evaluation is warranted and is appropriate.

OR

Consultation with a mental healthcare provider prior to this referral is (was) not possible because (give reason; e.g., geographic isolation from available mental healthcare provider, etc.)

4. Per references (a) and (b), you are entitled to the rights listed below:  
The right to obtain a second opinion and be evaluated by a mental healthcare provider of your own choosing, at your own expense, if reasonably available. Such an evaluation by an independent mental healthcare provider shall be conducted within a reasonable period of time, usually within 10 business days, and shall not delay nor substitute for an evaluation performed by a DoD mental healthcare provider.
  - a. The right to communicate without restriction with an IG, attorney, Member of Congress, or others about your referral for a mental health evaluation. This provision does not apply to a communication that is unlawful.



- b. The right, except in emergencies, to have at least two business days before the scheduled mental health evaluation to meet with an attorney, IG, chaplain, or other appropriate party. If I believe your situation constitutes an emergency or that your condition appears potentially harmful to your well being and I judge that it is not in your best interest to delay your mental health evaluation for two business days, I shall state my reasons in writing as part of the request for the mental health evaluation.
  - c. If you are assigned to a naval vessel, deployed or otherwise geographically isolated because of circumstances related to military duties that make compliance with any of the procedures in paragraphs (3) and (4), above, impractical, I shall prepare and give you a copy of the memorandum setting forth the reasons for my inability to comply with these procedures.
5. You are scheduled to meet with (name and rank of the mental healthcare provider) at (name of MTF or clinic) on (date) at (time).

(Signature)  
Rank and Name of Commanding Officer

I have read the memorandum above and have been provided a copy.

Service member's signature:\_\_\_\_\_ Date:\_\_\_\_\_

OR:

The Service member declined to sign this memorandum which includes the Service member's Statement of Rights because (give reason and/or quote Service member).

Witness's signature:\_\_\_\_\_ Date:\_\_\_\_\_

Witness's rank and name:\_\_\_\_\_ Date:\_\_\_\_\_

(Provide a copy of this memorandum to the Service member.)



# CHAPTER 6

## REPORTS, FORMS, AND RECORDS

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## CHAPTER 6. REPORTS, FORMS, AND RECORDS

### Section A - Reports.

1. Health Services Statistical Report, (RCN 6000-1).
  - a. The HSSR is produced by the Clinic Automated Management System (CLAMS) and is based on data entered at the terminal during the reporting month.
  - b. During production of the HSSR a set of screen prompts will allow entry of required information from the terminal keyboard. Prompt criteria include:
    - (1) Onboard staffing and billets for HSs, medical practitioners, and dental officers.
    - (2) Prescriptions. A number may already appear in this field. This number will be the number of prescriptions issued for the selected month (calculated from the database).
    - (3) Inspections. Count one for each inspection logged (e.g., galley, berthing, water, pool, food handlers).
    - (4) SAR. Count one for each SAR or MEDEVAC sortie (air or boat) with health services personnel aboard.
    - (5) Training Hours Given (medical officers). Count any medical training by medical officers (all hands, suturing demonstration, demonstrating knee injury evaluation to one or more HSs, hypothermia lecture for local boaters group, etc.) greater than 15 minutes duration. Total all training increments lasting longer than 15 minutes by all medical officers and round to the nearest hour.
    - (6) Expense Data (month). Enter the corresponding expenses for the selected month. Note: when starting the HSSR Report from a month other than October, it may be necessary to enter the year-to-year figures initially in order for the subsequent YTD figures to be correct.
    - (7) Expense Data (OPTAR). The corresponding Operating Target for the selected fiscal year. The amounts set initially will continue to appear, unless they are changed.
    - (8) Tickler OPFACs. CLAMS tabulates the percentage of USCG active duty persons in compliance with mandatory medical/dental requirements (shots, exams, audiograms, etc.) and displays this on the HSSR. Personnel in clinic/sickbay "Binnacle OPFACs" are automatically included in this "tickler file" scrutiny. Outlying units which fall within a clinic/sickbay's tickler radius but are too remote for binnacle reporting CLAMS calls "Tickler OPFACs". The user must enter these additional "Tickler OPFACs" at the time the HSSR is made. Once entered they will continue to display unless changed. NOTE: HSs at group/cutter sickbays are responsible for their own binnacle and "tickler" activity. This applies even in those situations where the majority of care for the group/cutter personnel is provided by a nearby USCG clinic.



- c. The report shall be submitted to the commanding officer for approval and signature by the FIFTH working day of the following month.
  - d. A signed copy of the HSSR shall be filed in the health care facility and be accessible for MLC audit.
- 2. Report of Potential Third Party Liability (RCN 6000-2). (Refer to Health Care Third Party Claims Recovery, COMDTINST 6010.16 (series) for current policy). Submit this report on form CG-4899 (Rev. 10-91), Report of Potential Third Party Liability. A sample form CG-4899 (Rev. 10-91) is included as Figure 6-A-1. If applicable, attach to Nonfederal Health Care Certification Form, CG-5534, when submitting nonfederal health care bills for processing.
- 3. MLC/Headquarters Clinic Operations Report (RCN 6000-3). Generate and submit the MLC/Headquarters Report in accordance with the instructions contained in the CLAMS User's Guide. This report is submitted on disk or transmitted electronically to Commandant (G-K) monthly for clinics and every 6 months (October/April) for sickbays. Outpatient health care of non-USCG patients and dental statistical reporting are incorporated into this report. Reports from clinics and sickbays must be sent to Commandant (G-K) within five working days of the following month. Delay of report submission from sickbays is permissible should operational commitments (e.g., underway) interfere with timely reporting.
- 4. Disease Alert Report (RCN-6000-4). Disease Alert Reports provide appropriate commands with information that can be used to protect lives and health, and maintain command effectiveness. Detailed instructions are contained in Section 7-B of this manual.
- 5. Report of Theft of Controlled Substances (RCN 6000-5).
  - a. Discrepancies noted on Controlled Substance Inventory Board Reports shall be investigated as discussed in Chapter 10 of this manual. Submit findings to appropriate MLC (K).
  - b. MLC (K) shall review and determine further action, including whether a Form DEA-106 shall be submitted. A copy of all DEA-106 reports submitted shall be sent to Commandant (G-WKH).
- 6. Inpatient Hospital Report (RCN 6000-6). When notified that a member of the Coast Guard is hospitalized, transferred to another facility, or discharged from inpatient status, the unit commanding officer shall notify the appropriate MLC (p) and (k) via message in accordance with current MLC directives. When listing diagnosis, use only ICD-9 codes; do not include a description of the ailment. See Paragraph 2-A-2 of this manual for additional policy concerning emergency care at other than Coast Guard or DOD facilities. CLAMS also produces a letter containing this information.



7. Health Care Equipment Inventory Report (RCN 6000-7). Health care equipment inventories are maintained by the MLCs' and are used for planning and budgeting purposes. All units with health care equipment shall verify their health care equipment inventory. Annually, in January, MLC (k) will forward to each unit within their area of responsibility a copy of their previous health care equipment inventory report. Units shall annotate changes and submit to MLC (k) with their annual budget request. MLC (k) will compile all inventories and forward them to Commandant (G-WKH) in conjunction with separate entity from the unit's personal property list. This inventory report reflects only major health care equipment or items with an original cost of more than \$300.00.
8. Health Services Division Status Report (RCN 6000-8). This annual report provides Headquarters and MLCs' with individual clinics' status, problems, and initiatives in the medical, dental, pharmacy, and quality assurance areas. See Commandant Instruction 6010.22(series) for specific instructions regarding preparation and submission of this report.
9. Shorten Clinic Automated Report System (SCARS). Sickbays that have not been able to implement CLAMS can use SCARS to produce the MLC/Headquarters Clinic Operations Report until they are able to use CLAMS. Note that the semiannual MLC/Headquarters Clinic Operations Report (RCN 6000-3) is separate and distinct from the monthly Health Services Statistical Report (RCN 6000-1). Sickbays having to produce an HSSR without benefit of CLAMS will follow the HSSR format found in the CLAMS User's Guide, but need not complete the "Onboard billet percent", "Binnacle data", and workload items which do not apply to their operations. SCARS prompts the HS to enter data totals in response to a succession of screen prompts. Six months totals for outpatient visits (OPVs), prescriptions filled, lab test done, HBA visits, inspections, referrals, SARS, and expense data will be sought. The percent of active duty and civilian employees in compliance with mandate requirements (like audiogram, HIV test, etc.) must also be complied and entered. Six month totals can be tabulated from HSSRs. Compliance percentages are calculated by SCARS. (Number in compliance divided by the number for whom the requirement applies. If you have 30 people in the hearing conservation program and 15 have had an audiogram in the last year, your compliance is  $15/30 \times 100$ ; or 50%).



Figure 6-A-1

|  |  |  |  |
|--|--|--|--|
| DEPARTMENT OF<br>TRANSPORTATION<br>U.S. COAST GUARD<br>CG-4899 (Rev-04-01)   |  | <b>REPORT OF POTENTIAL THIRD PARTY LIABILITY</b>   |  |
| <b>INSTRUCTIONS:</b> Complete all blocks to the best of your knowledge. If unknown or not applicable, leave blank. Mail original to Commandant (G-WRP-2) and a copy to appropriate MLC (k).  |  |  |  |
| <b>SECTION I – IDENTIFICATION OF INJURED PERSON</b>  |  |  |  |
| <b>A. NAME</b> (Last ,First and Middle Initial)  |  | <b>B. SSAN</b>   | <b>C. RANK/RATE</b>  |
| <b>E. HOME ADDRESS</b> (Including zip code)  |  | <b>F. DATE OF BIRTH</b>  | <b>D. WORK TELEPHONE</b><br><input type="checkbox"/> FTS <input type="checkbox"/> COMM |
| <b>H. STATUS OF BENEFICIARY</b><br><br><input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RESERVE <input type="checkbox"/> RETIRED<br><br><input type="checkbox"/> DEPENDENT (Complete Section 2 below)   |  | <b>I. UNIT NAME</b>  | <b>G. HOME TELEPHONE</b>   |
| <b>SECTION 2 – IDENTIFICATION OF SPONSOR</b><br>(Complete only if injured person is a dependent; otherwise, leave blank)   |  |  |  |
| <b>A. NAME</b> (Last ,First and Middle Initial)  |  | <b>B. SSAN</b>   | <b>C. RANK/RATE</b>  |
| <b>E. HOME ADDRESS</b> (Including zip code)  |  | <b>F. HOME TELEPHONE</b>   | <b>D. WORK TELEPHONE</b><br><input type="checkbox"/> FTS <input type="checkbox"/> COMM |
| <b>G. STATUS OF BENEFICIARY</b><br><br><input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RESERVE <input type="checkbox"/> RETIRED  |  | <b>H. UNIT NAME</b>  | <b>I. BRANCH OF SERVICE</b>  |
| <b>SECTION 3 - ACCIDENT</b>  |  |  |  |
| <b>A. ACCIDENT INFORMATION</b> (Include zip code with address):<br><br><input type="checkbox"/> AUTOMOBILE (city/state):<br><input type="checkbox"/> JOB RELATED (employers name/address):<br><input type="checkbox"/> PROPERTY RELATED (owners name/address): |  |  | <b>B. DATE AND TIME</b>  |
| <b>C. BRIEFLY DESCRIBE THE ACCIDENT</b> (include who caused the injury and how it happened):   |  |  |  |
| <b>SECTION 4 – ATTORNEY INFORMATION</b>  |  |  |  |
| <b>A. NAME OF YOUR ATTORNEY</b>  |  | <b>B. ADDRESS</b> (Include zip code)   | <b>C. TELEPHONE NUMBER</b>   |
| <b>SECTION 5 – AMBULANCE SERVICE</b>   |  |  |  |
| <b>A. NAME OF AMBULANCE</b>  |  | <b>B. ADDRESS</b> (Include zip code)   | <b>C. TELEPHONE NUMBER</b>   |
| <b>MAIL TO:</b><br>Commandant (G-WRP-2)<br>U.S. Coast Guard<br>2100 2 <sup>nd</sup> St. S.W.<br>Washington, DC 20593-0001  |  | <b>PRIVACY ACT STATEMENT</b><br>Sections 2651-2563 of Title 42 to the U.S. Code authorize collection of this information. Furnishing the Social Security No. is empowered by Exec. Order 9397 and is mandatory to identify authorized beneficiaries. This information is principally used to document incidents that lead to injured party(ies) receiving medical care at the expense of the U.S. Coast Guard. Routine uses including lawful enforcement and investigations for recovery from third party liability. <b>If the requested information is not furnished, recovery of Federal funds may be hampered, possibly limiting continued delivery of comprehensive health care.</b> |  |



Figure 6-A-1 (reversed)

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| <b>SECTION 6 – MOTOR VEHICLE ACCIDENT</b><br>(DATA PERTAINING TO VEHICLE IN WHICH YOU WERE DRIVING OR RIDING)  |                                   |                                    |  |
|--|-----------------------------------|------------------------------------|--|
| A. NAME OF DRIVER Military? <input type="checkbox"/> YES <input type="checkbox"/> NO   |                                   | B. HOME ADDRESS (Include zip code) | C. WORK TELEPHONE<br><input type="checkbox"/> FTS <input type="checkbox"/> COMM  |
| D. NAME OF OWNER Military <input type="checkbox"/> YES <input type="checkbox"/> NO   |                                   | E. YEAR/MAKE/MODEL OF AUTOMOBILE   | F. LICENSE PLATE NUMBER  |
| G. OWNER'S INSURANCE COMPANY AND POLICY NUMBER   |                                   | H. ADDRESS(ES) (Include zip code)  | I. TELEPHONE NUMBER  |
| J. NAMES OF INJURED PASSENGER(S)   |                                   | K. ADDRESS(ES) (include zip code)  | L. TELEPHONE NUMBER  |
|  |                                   |                                    |  |
| <b>(DATA PERTAINING TO OTHER VEHICLE)</b>  |                                   |                                    |  |
| M. NAME OF DRIVER Military? <input type="checkbox"/> YES <input type="checkbox"/> NO   |                                   | N. ADDRESS (Include zip code)      | O. TELEPHONE NUMBER  |
| P. NAME OF OWNER Military <input type="checkbox"/> YES <input type="checkbox"/> NO   |                                   | Q. YEAR/MAKE/MODEL OF AUTOMOBILE   | R. LICENSE PLATE NUMBER  |
| <b>SECTION 7 – ALL OTHER ACCIDENTS</b><br>(DATA PERTAINING TO INSURANCE OTHER THAN AUTOMOBILE)   |                                   |                                    |  |
| A. RESPONSIBLE PARTY'S INSURANCE COMPANY AND POLICY NUMBER   |                                   | B. ADDRESS (Include zip code)      | C. TELEPHONE NUMBER  |
| D. TYPE OF INSURANCE<br><input type="checkbox"/> HOME OWNERS <input type="checkbox"/> PERSONAL MEDICAL INSURANCE <input type="checkbox"/> WORKERS COMPENSATION |                                   |                                    |  |
| E. INJURED PARTY'S INSURANCE COMPANY AND POLICY NUMBER   |                                   | F. ADDRESS (Include zip code)      | G. TELEPHONE NUMBER  |
| H. TYPE OF INSURANCE<br><input type="checkbox"/> HOME OWNER <input type="checkbox"/> PERSONAL MEDICAL INSURANCE <input type="checkbox"/> WORKERS COMPENSATION  |                                   |                                    |  |
| <b>SECTION 8 – MILITARY/CIVILIAN HOSPITALIZATION</b>   |                                   |                                    |  |
| A. NAME OF HOSPITAL(S)   | B. ADDRESS(ES) (Include zip code) | C. DATE(S) OF TREATMENT<br>FROM TO | D. PAYMENT MADE BY:<br><input type="checkbox"/> SELF<br><input type="checkbox"/> INSURANCE<br><input type="checkbox"/> CHAMPUS |
|  |                                   | FROM TO                            | <input type="checkbox"/> SELF<br><input type="checkbox"/> INSURANCE<br><input type="checkbox"/> CHAMPUS                        |
| <b>SECTION 9 – MILITARY/CIVILIAN DOCTORS/DENTISTS</b>  |                                   |                                    |  |
| A. NAME OF DOCTORS   | B. ADDRESS(ES)                    | C. DATE(S) OF TREATMENT<br>FROM TO | D. PAYMENT MADE BY:<br><input type="checkbox"/> SELF<br><input type="checkbox"/> INSURANCE<br><input type="checkbox"/> CHAMPUS |
|  |                                   | FROM TO                            | <input type="checkbox"/> SELF<br><input type="checkbox"/> INSURANCE<br><input type="checkbox"/> CHAMPUS                        |
|  |                                   | FROM TO                            | <input type="checkbox"/> SELF<br><input type="checkbox"/> INSURANCE<br><input type="checkbox"/> CHAMPUS                        |
| E. IS TREATMENT COMPLETE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, WHEN DO YOU EXPECT IT TO BE COMPLETE? _____                       |                                   |                                    |  |



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## Section B - Forms and Records.

### 1. Status-Profile (CG-5460A).

- a. Purpose. CG-5460A shall be used by active duty persons and civilian employees who are either signing into the clinic/sickbay for the first time under CLAMS, or need a duty status chit. It has a limited space for patient identification at the top, a duty status slip (with copies) in the middle, visit information on the lower half, and a detailed patient information section on the back. See Figure 6-B-1.
- b. Detailed Instructions.
  - (1) Top Left. Mechanical imprinting of patient's name, if available. Have the patient fill in the appropriate data if mechanical imprinting is not used.
  - (2) Top Right. Date of visit is entered by the patient. The sponsor's social security number (SSN) and status (active duty or civilian employee) are also required if mechanical imprinting is not used.
  - (3) Rear. For a patient's first clinic visit after installation of the CLAMS data base, more information is required on the form.
  - (4) Middle Section. Duty status chits are issued under CLAMS in the same manner as they were before CLAMS. Fit for duty (FFD) chits are required for grounded members cleared for aviation duties, and for members returned to full duty before their restricted duty status has expired. The provider fills out and signs the duty status chit (with firm pressure, because two tear-off patient copies are produced at the same time). DIF (under FIT FOR FULL DUTY) stands for Duties Involving Flight.
  - (5) A diagnosis must be included on each duty status chit issued, including FFD chits. If the practitioner does not want the diagnosis to appear on the binnacle list, enter an asterisk (\*) after the written diagnosis. Thus a data base entry of "gonorrhea\*" will appear as " " on the binnacle list. If inpatient, place a "\$" after the diagnosis. The status on the binnacle list will then appear as NFFD (INPT).
  - (6) If the illness or injury resulting in the duty restriction was (S)ports, (O)ccupational, (M)otor vehicle, or (A)lcohol related, check the applicable (S)(O)(M)(A) block(s). More than one block can be checked if appropriate.
  - (7) Lower Half. This portion is for recording specific workload information. If the visit meets the criteria as an outpatient visit (OPV), as defined by Paragraph 6-B-1.c. of this manual, the caregiver's initials are required. For medical and dental record purposes, the OPV caregiver is the individual who ultimately assumes responsibility for the patient's treatment. You are the caregiver for a visit if:



- (a) your SOAP note is recorded in the health record;
  - (b) you assumed ultimate responsibility for the patient's treatment; and
  - (c) you signed the medical record entry.
- (8) Answering a question about a finding or treatment for another practitioner does not make you the caregiver of record. Also, a health services technician who performs a preliminary assessment (history, exam, and a plan) and then turns the patient over to a medical officer or other practitioner is not the OPV caregiver and should not initial a box. A telephone call by a health services technician to the duty practitioner in regard to a patient may constitute a transfer of responsibility, provided the duty practitioner's assessment and plan are recorded in the health record for his signature.
- (9) Left Side (lower half). There are two boxes available for OPV caregiver initials. A physician, physician assistant, nurse practitioner, physical therapist, mental health practitioner, health services technician, or medical extern initials the first box. The second box is also used when another problem which meets the OPV criteria is addressed by a second practitioner.
- (a) Check one visit length: "Limited" (less than 15 minutes), "Intermediate" (15-30 minutes), or "Extended" (more than 30 minutes), based on the number of minutes the OPV caregiver actually spent with the patient or working on the patient's problem (reading x-rays, checking lab work, etc.).
  - (b) In the column of boxes under the visit length, indicate the type(s) of care provided during the visit. Use check marks for all boxes except initials (discussed above), audit codes, lab test(s), and medical x-rays. Check "routine exam" box only when an SF-88 type exam is done on an active duty member.
  - (c) If the OPV deals with one of the audit codes listed on the back of the form, place the appropriate 2 letter code in the audit code box. These codes will help you generate lists of patients for the quality assurance monitoring and evaluation audits, and will save you the time and effort which would otherwise be required to prepare a list of patients seen for a particular problem.
  - (d) Clinics may create their own codes for their own purposes if desired. These would be in addition to the audit codes listed on the back of the form. Two codes may be entered for each OPV. CLAMS will allow searching for any additional codes that may be developed.
  - (e) Lab and X-ray. Enter the number of tests performed.



- (f) Health benefits advice by itself does not constitute an OPV. However, facilities shall account for work and time expended performing this function. For episodes of health benefits advice (by telephone or in person) lasting more than three minutes, the advisor shall enter his/her initials in the box provided.
  - (g) There is no block for recording prescription count. Prescription counts will be automatically tallied by the pharmacy module of CLAMS. Patients using the pharmacy only (outside prescription or a refill) do not need to fill out a Status-Profile or Visit profile form, except for their first visit when you will need all patient information. If for some reason you are not using CLAMS for this purpose, you will be prompted to enter your total number of prescriptions filled when you are printing the HSSR.
  - (h) Check the NON-OPV box if no aspect of medical or dental care meets the criteria for an OPV. If you check NON-OPV, do not enter OPV caregiver(s) initials.
- (10) Center (lower half). Place provider initials in the box by any referral(s) made or ordered. Initial the FED (Federal facility, e.g., USMTF, USTF) or NFED (non-federal, e.g., non-fed med, supplemental care, TRICARE, outside contract, etc.) column, as appropriate.
- (a) In-house referrals to contract providers as well as referrals to other Coast Guard clinics are exempt from this reporting. Do not mark a referral box for one of these.
  - (b) Check the box for any tickler items performed.
  - (c) Check the box for third party, if applicable.
  - (d) Note dental referrals by circling the appropriate letter:
    - 1 D - Prosthodontics
    - 2 E - Endodontics
    - 3 P - Periodontics
    - 4 O - Orthodontics
    - 5 S - Oral Surgery
    - 6 K - Pedodontics
- (11) Right Side (lower half). Dental follows the same general guidelines as the left (medical) side, e.g., the initials of the attending dental officer, dental extern,



health services technician, or dental hygienist go in the OPV Caregiver box, whereas the person who performs a simple prophylaxis initials the box labeled "Prophy Giver."

- (a) Initial the "Prophy Giver" box if a prophy is performed. If the patient is treated in any other manner, initial the "OPV Caregiver" box.
- (b) If an annual or semiannual Type 2 dental exam is performed, record "1" in the "Exam" box. Do not record any numeral other than "1". Do not take credit for post-op visits, perio exams, etc. in this box. A "1" in this box sets a tickler file, and it should not be polluted with less-than-thorough hard and soft tissue exams.
- (c) If an unscheduled patient is seen for emergency treatment, record "1" in the Emergency box.
- (d) Record the number of teeth restored in the "Restoration(s)" box. (For example, a maxillary first molar with MO and OL restorations placed counts as 1 tooth restored. Pins, bases, number of attempts, etc., do not alter the method of counting.)
- (e) Record the number of surfaces restored in the "Surface(s)" box. Pins, bases, etc., do not affect the number of surfaces restored.
- (f) Record the number of canals permanently sealed in the "Root Canal(s)" box.
- (g) In the "Pulpotomy(ies)" box, record the number of primary tooth pulpotomies performed as a definitive treatment. Also, record the number of symptomatic permanent teeth opened, pulpotomized, and referred to a specialist for definitive therapy.
- (h) Record the number of impacted teeth (soft tissue or bony) extracted in the "Impactions" box.
- (i) Record the number of non-impacted teeth extracted in the "Extractions" box.
- (j) Record the number of other surgical procedures (e.g., periodontal surgery, free gingival graft, alveoplasty, biopsy, ridge reduction, etc.), per quadrant, in the "Other Surg/Quad" box.
- (k) Record the number of quadrants treated with non-surgical perio therapy (curettage and root planing, usually with anesthesia) in the "Non-Surgical Perio/Quad" box. Also, include a thorough periodontal examination and charting (NOT PSR) as 1 quadrant of non-surgical perio treatment. Only dental officers may record non-surgical perio treatment. No more than



two quadrants may be recorded per visit. Generally, no other therapy should be recorded for this visit; non-surgical perio is a planned step in definitive perio therapy. Only patients with documented periodontal disease receive non-surgical perio therapy. A prophylaxis should be scheduled at a separate visit. Full-mouth cavitron therapy is a prophylaxis, not four quadrants of non-surgical perio.

- (l) Record the number of teeth (not surfaces) sealed, or receiving preventive resins, in the "Sealant" box.
- (m) Record the number of treatment appliances (e.g., orthodontics, spacers, habit devices, stents, mouthguards, etc.), one per arch, delivered or adjusted, in the "Treatment Appliances/Arch" box.
- (n) Record the number of full or partial dentures delivered in the "Denture Partial/Full/Arch" box.
- (o) Record the number of permanently cemented cast units, other than resin-bonded retainers (Maryland bridges), in the "Cast Unit(s)" box. Pontics count as one cast unit apiece.
- (p) Record the number of acid etch units (Maryland bridges, resin-bonded retainers) bonded in the "Acid Etch Units" box. Count each pontic and each wing as one unit.
- (q) If a dental officer returns to the clinic to care for a beneficiary after hours, record 1 in the "After Hours OPV" box.
- (r) If a dental officer engages in a diagnostic/therapeutic conversation with a patient over the phone, and the patient's dental record is so noted in SOAP format, record "1" in the "Telephone OPV" box.
- (s) At the end of the visit, enter the dental classification, in arabic numerals, in the "Class" box.
- (t) Enter the number of minutes required for diagnosis (for either Annual Exam or Emergency visits) in the "Dx Minutes" box.
- (u) Enter the sum of the PSR scores (for Annual Exams) in the "PSR Total" box.
- (v) If a biopsy is done, check the "Biopsy" box to set a tickler file. Also indicate a surgical procedure in the "Other Surg/Quad" box.
- (w) If a dental procedure is begun, but not finished, during a visit, the dental caregiver shall initial the (dental) OPV Caregiver box for an OPV credit,



but shall not put a number in a box below until the treatment is completed during a subsequent visit.

- c. Definition of an Outpatient Visit (OPV or "visit"). For the purposes of this instruction, an OPV occurs each time an eligible beneficiary presents to a Coast Guard Medical Treatment Facility (medical or dental) for examination, diagnosis, treatment, evaluation, consultation, counseling or advice; or is treated or observed in quarters; and a signed and dated entry is made in the patient's health record, dental record, or other record of medical treatment (See Note 1 following 6-B-1.c.(3)). An exception is that consecutive visits to specialty clinics (e.g., physical therapy and occupational therapy) will not require a signed and dated entry for each visit unless there is a change in the prescribed treatment or a significant physical finding is evident. In all instances, however, an acceptable record audit trail shall be maintained. A clinic log shall be maintained as a source document to support an audit trail.
- (1) Classification of a service as a visit is not dependent upon the professional level of the person providing the service (includes medical officers, dental officers, dental hygienists, optometrists, nurses, and health services technicians).
  - (2) A patient visiting a Coast Guard Medical Treatment Facility (CGMTF) in the morning and again in the afternoon shall count as two visits (providing the requirements of Note 1 are satisfied). Conversely, avoid double counting; for example, a visit during which both a medical officer and a health services technician (in the same clinic) have been involved shall count as only one visit. Other examples of patient health care contacts occurring at the CGMTF which shall be included and counted as visits are:
    - (a) Each time a patient is seen in the CGMTF, even if referred elsewhere for admission.
    - (b) Each time a patient is seen in the CGMTF's urgent care room, or other designated area outside of regularly established clinic hours.
    - (c) Each time medical or dental advice or consultation is provided by telephone and is properly documented in the health care records. (See Note 1.)
    - (d) Each time a therapist provides primary care (e.g., patient assessment while serving in a physician extender role) and then refers a patient for specialized treatment in that same clinic, then one visit for primary care and one visit for treatment shall be counted.
    - (e) Each time an examination, evaluation, or treatment is provided in the home, school, community center, or other location outside the CGMTF by a staff member from the CGMTF.



- (f) Subject to the provisions of Note 1, each time one of the following tasks is performed when not a part of routine medical care, and provided it is associated with a physical examination or treatment for a specific condition requiring follow-up: therapeutic or desensitization injections; cancer detection checks (e.g., PAP smears); blood pressure checks; weight checks; and new prescriptions (do not include refills).
  - (g) Each time a screening physical examination is performed (e.g., school or employment examination), providing an appropriate health record entry is made (See note 1).
- (3) Nonvisits. DO NOT report the following as visits:
- (a) Prescriptions from health care providers outside the CGMTF, chest x-ray surveys/examinations, laboratory tests, immunizations, or other diagnostic or screening test that are not part of a specific treatment.
  - (b) Furnishing of health care advice or information, either directly or by telephone, that does not satisfy the requirements of Note 1.

Note 1. The key to reporting visits is adequate documentation on appropriate medical records, e.g., SF-600, SF-513, and all records of treatment to support an audit trail. For example, “refill prescription for birth control pills” with date and signature of the health care provider is not sufficient. The entry should indicate that discussion of use of pills and counseling did take place, for example, “discussed with patient; no apparent problem with use-patient advised to have a PE and PAP prior to next request for renewal; 6 months prescription for ovulen given.”

- (c) Visits to other MTFs or private sector facilities, even when referred from the CGMTF. The CGMTF already receives credit for an OPV for the visit that generated the referral (see 6-B-1.c.(2)(a)).
2. Visit Profile (CG-5460B). This form must be used by all dependents and retirees who are signing into the health care treatment facility for treatment. It can also be used by active duty and civilian employees if they have previously been entered into the CLAMS database and do not need a duty status chit. If a visit profile form is started on a patient who turns out to need a duty status chit, discard the Visit Profile and start over on a Status-Profile. Visit Profile sheets should be used by most active duty patients for the dental clinic, most non-sickcall visits (except refill or filling outside prescription), health benefit visits, weight checks, follow-up lab testing, immunizations, allergy shots, audiogram, etc. See Figure 6-B-2.
- a. Top Half. A new patient must fill out all information on the top half of the form. A staff member (front desk or provider) should carefully review the form completeness before the patient leaves the building since the patient cannot be properly entered into the data base without all of this information.



- b. Top Left. Mechanical imprinting of the patient's name, if available; if not, the patient fills in. Reason For Visit box is optional and is provided for facility triage.
  - c. Date (top right) must be filled in at each visit.
  - d. Top Right. If mechanical imprinting was not used or if the addressograph card lacks some information, this section should be filled in at each visit. Otherwise, leave blank.
  - e. Bottom. The Third Party block is to be filled out by the clinic staff. Note that it includes dependent/retiree referral for inpatient care at a DOD facility.
  - f. Reverse. Blank except for Privacy act information and audit codes. This is a good place to put any addresses to which request for old medical records should be sent.
  - g. The bottom half of this form is virtually identical to the Status-Profile form. Refer to the Status-Profile form instructions for these sections.
3. U.S. Coast Guard Health Care Equipment Request (CG-5211). Definitions for major and minor health care equipment, health care equipment procurement procedures, and the criteria used to approve health care equipment requests are described below.
- a. Definitions.
    - (1) Major health care equipment. Any item of health care equipment which meets the following criteria:
      - (a) costs \$1000.00 or more;
      - (b) does not lose its identity when installed or placed into service; and
      - (c) has a life expectancy of one year or more.
    - (2) Minor health care equipment. Health care equipment that costs at least \$300.00, but less than \$1000.00, and meets the criteria described above.
  - b. Health Care Equipment Requests.
    - (1) Major Health Care Equipment. Units shall submit requests for major health care equipment on form CG-5211 (see Figure 6-B-4) the appropriate MLC (K). If the MLC (K) is unable to evaluate the CG-5211 within 15 working days of receipt, MLC (K) shall notify the commanding officer of the requesting unit regarding the delay. Each MLC (K) shall review the request and provide a forwarding endorsement that, as a minimum, addresses the following areas:
      - (a) how the equipment is or is not appropriate for the requesting health care facility;
      - (b) why the purchase is or is not cost effective; and



- (c) how the equipment will or will not impact on the quality of patient care.
- (2) Commander MLC(k) will evaluate major health care equipment requests, and within 30 days of receipt of the CG-5211, will notify the unit that one of the following actions will be taken:
  - (a) purchase of the requested equipment;
  - (b) purchase of a substitute item of a different make or model in order to standardize health care equipment and/or ensure cost effectiveness;
  - (c) or return the request via the chain of command with an explanation of why the equipment request was disapproved.
- (3) Minor Health Care Equipment. Units shall submit requests for minor health care equipment, using form CG-5211, to the appropriate MLC (K). If the MLC (K) is unable to evaluate the CG-5211 within 15 working days of receipt, the MLC (K) shall notify the commanding officer of the requesting unit regarding the delay. Commanders (k), MLCs may disapprove the request or approve the request and provide funding.
- (4) Health care equipment costing less than \$300.00 is a unit responsibility and shall be purchased using unit funds.
- (5) Emergency Procurement. A request for an emergency procurement may be relayed to the appropriate MLC (K) by telephone, followed by a faxed copy of a completed form CG-5211.

c. Criteria for Approval of Health Care Equipment Requests.

- (1) Factors For Replacing Equipment. The fact that an item of health care equipment is approaching, or has passed, its normal life expectancy is not considered sufficient cause for replacement in and of itself. Units that request replacement equipment shall provide justification on the CG-5211. Factors which are considered sufficient cause for equipment replacement include:
  - (a) documented unreliability of equipment, demonstrated by unusual maintenance expenses or high frequency of repairs;
  - (b) excessive repair costs, onetime or repetitive; or
  - (c) equipment is obsolete and new technology exists that reduces pain and discomfort, improves treatment, increases diagnostic accuracy, significantly reduces costs by conserving personnel, supplies, or utilities, or increases efficiency by reducing patient treatment time.
- (2) Factors For Initial Procurement. Due to changes in the beneficiary population or unit mission, a health care facility may require health care equipment not previously held by that facility. Units requesting an initial procurement shall provide justification of form CG-5211.



4. Health Record Receipt Form (NAVMED 6150/7). The Health Record Receipt Form shall be used as a permanent record of receipt and disposition of health records which are maintained at Coast Guard health care treatment facilities.
  - a. Detailed instructions.
    - (1) For each health record maintained at Coast Guard facilities, complete the first four lines of a Health Record Receipt form and place into the health record folder.
    - (2) Whenever the health record is temporarily removed from the files, complete the charge-out information required on the bottom half of the Health Record Receipt, and retain in the health record file where that record is normally kept. Return the Health Record Receipt to the record when it is returned to the file.
    - (3) When a member departs from a unit on permanent change of station, or TAD for over 30 days, forward their health record to servicing PERSRU for transmittal to gaining PERSRU.
      - (a) When the record is forwarded, enter the following in the "REMARKS" section of NAVMED 6150/7:  
Date \_\_\_\_\_.  
Health record mailed to servicing PERSRU this date.  
\_\_\_\_\_.  
HS's Signature
      - (b) Cut the form at the double lines above the "INSTRUCTIONS" section, and maintain the top section on file for two years.
5. Referral for Civilian Medical Care (DD-2161). This dual-purpose form shall be used to refer non-active duty patients from Coast Guard facilities to nonfederal facilities, either for supplemental health care or when the patient is disengaged from care. The DD-2161 will also be used to disengage non-Coast Guard active duty patients from Coast Guard facilities when the scope of care is beyond the ability of the Coast Guard to provide such care. The Coast Guard facility shall contact the parent service to ensure the active duty patient has the proper direction on where to obtain necessary care. A signed DD-2161 disengaging the patient will accompany the patient when he departs the Coast Guard facility and a copy shall be kept on file. When used to refer patients for supplemental health care, include a copy with the CG-5534 when the invoice for care is submitted for payment. Complete appropriate sections on top and reverse of form when disengaging a patient from care. Maintain a file of copies of completed forms.
6. Health Services Log. Each unit with health services personnel shall maintain a Health Services Log. This log is used to document the daily operations of the clinic or sickbay. At a minimum it is used to record all individuals reporting to sick call or for treatment, inspections and inventories conducted, and the results of potable water test.



- a. Sickbays and clinics shall submit the Health Services Log to the commanding officer for review, approval, and signature on a schedule to be determined by the commanding officer.
  - b. The patient listing portion of the Health Services Log can be produced by CLAMS. At a minimum it must contain the name of patient, date of visit, Division or Department, members unit OPFAC (for active duty Coast Guard only), and branch of service.
7. Binnacle List. The Binnacle List can be produced by CLAMS. At a minimum it must be sorted by OPFAC and Department/Division and include patient name, diagnosis (command discretion), status, date of onset of status, and duration of status or date of status expiration. The Binnacle Lists(s) shall be distributed to local command(s) as determined by the health care facility command.
8. Adult Preventive and Chronic Care Flowsheet Form (DD2766). This form should replace the now obsolete Summary of Care Form (NAVMED 6150/20) as a means of documenting significant chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, PPD, DNA & HIV testing screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exams, etc.), and chart audits. Medical officers should familiarize themselves with the use of this form prior to its widespread use at their clinics. It is recommended that an in training session be provided to all medical providers at the CG clinic, before the forms are placed in the health records. The old Problem Summary List presently used on the Coast Guard AD health records can then be removed after the information contained in it is copied onto the DD2766 form. The process to complete this form is mostly self-explanatory. Only three items contained in this form do not apply to the Coast Guard. These items, which are located on page 3, are 8.a, 10.e, and 10.i. Only a pencil shall be used to darken the circles present on the flow chart of page 2 section 7. Item 11, located on page 3, is used to document the completion of the pre & post deployment questionnaires that are required for CGAD members who deploy with DOD. The medical officer should enter the location and date of every deployment that the AD member participates in.



Figure 6-B-1

| DEPARTMENT OF<br>TRANSPORTATION<br>U.S. COAST GUARD<br>CG-5460A (Rev. 9-92)  |                    | <b>STATUS PROFILE</b><br><small>PRINT OUT ON CARBONLESS PAPER<br/>New Patient Information and Privacy Act Statement on Page 2</small>  |  | DATE<br><small>Month   Day   Year</small>   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|--|--------------------|--|--|---|-----------|------|--|---------|--|--|--------------------|--|--|-------------|--|--|-----------|--|--|-----|--|--|-----|--|--|------------------|--|--|--------|--|--|-------------------|--|--|-----------|--|--|---------------|--|--|-------------|--|--|-------|--|--|------------|--|--|------------------|--|--|---------|--|--|--|----------------|--|--|-----------|--|-----------------|--|-----|--|-----------|--|--------------------|--|--------------|
| <b>NAME</b><br><br><div style="display: flex; justify-content: space-between;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Last</span> <span>First</span> <span>MI</span> </div>   |                    | <b>SPONSOR'S SOCIAL SECURITY NUMBER</b> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 100px; height: 20px;"></div> <div style="border: 1px solid black; width: 100px; height: 20px;"></div> <div style="border: 1px solid black; width: 100px; height: 20px;"></div> <div style="border: 1px solid black; width: 100px; height: 20px;"></div> <div style="border: 1px solid black; width: 100px; height: 20px;"></div> <div style="border: 1px solid black; width: 100px; height: 20px;"></div> <div style="border: 1px solid black; width: 100px; height: 20px;"></div> <div style="border: 1px solid black; width: 100px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between;"> <span>Active</span> <input type="checkbox"/> </div> <div style="display: flex; justify-content: space-between;"> <span>Civilian</span> <input type="checkbox"/> </div> <div style="display: flex; justify-content: space-between;"> <span>Employee</span> <input type="checkbox"/> </div> |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  |                    | <b>Purpose of Visit</b><br><div style="border: 1px solid black; height: 20px;"></div>  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  |                    | <b>NEW PATIENTS:</b> Please complete information on reverse side   |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  |                    | - CLINIC USE ONLY BELOW THIS LINE -  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
| <b>DUTY STATUS</b><br><b>LIMITATIONS</b><br><input type="checkbox"/> Desk Work Only<br><input type="checkbox"/> Grounded<br><input type="checkbox"/> No Sports or PT<br><input type="checkbox"/> No Boat or Sea Duty<br><input type="checkbox"/> No Prolonged Standing or Walking<br><input type="checkbox"/> Work Hours as Tolerated<br><input type="checkbox"/> No Climbing<br><input type="checkbox"/> No Lifting Over<br><input type="checkbox"/> No Use of:<br><input type="checkbox"/> Other                               |                    | <input type="checkbox"/> <b>FIT FOR FULL DUTY</b><br><input type="checkbox"/> <b>OK DIF/DUNKER/CHAMBER</b><br><input type="checkbox"/> <b>LIMITED DUTY</b><br>For _____ Day (s)  |  | <input type="checkbox"/> <b>NOT FIT FOR DUTY</b><br>For _____ Day( s)   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  |                    | <b>DIAGNOSIS</b><br><div style="display: flex; justify-content: space-between;"> <span>S</span><input type="checkbox"/> <span>D</span><input type="checkbox"/> <span>M</span><input type="checkbox"/> <span>A</span><input type="checkbox"/> </div>  |  | <input type="checkbox"/> <b>SIQ</b><br><input type="checkbox"/> <b>Inpatient</b>  |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  |                    | <b>RETURN TO CLINIC</b> <input type="checkbox"/> Return to clinic as needed for follow-up<br><input type="checkbox"/> Flight Surgeon evaluation required for return to duties involving flight   |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  |                    | <b>SIGNATURE</b><br><div style="border: 1px solid black; height: 20px;"></div>   |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
| <b>MEDICAL OPV(s)</b><br>Provider's initials<br><div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> </div> Limited Visit (0-15)<br>Intermediate (15-30)<br>Extended (>30)<br>Audit Code (s)<br>After Hours OPV<br>Lac Repair/Cast/Splint<br>Biopsy<br>Narrative Summary<br>Pap<br>Telephone OPV<br>Routine Exam<br>Subst/Overseas<br>OMMIP Basic Exam<br>Command Afloat |                    | <b>ACCIDENT/THIRD PARTY</b><br><input type="checkbox"/> Check if this accident could result in a third party claim.  |  | <b>DENTAL OPV(s)</b><br>OPV Caregiver<br>Propriety Giver<br>Annual Exam<br>Emergency<br>Restoration (s)<br>Surfaces (s)<br>Root Canal (s)<br>Pulpotomy (ies)<br>Impaction (s)<br>Extraction (s)<br>Other Surg/Quad<br>Non-Surg Perio/Quad<br>Sealant (s)<br>Treatment Appliances/Arch<br>Denture Partial/Full/Arch<br>Cast Unit (s)<br>Acid Etch Unit (s)<br>After Hours OPV<br>Telephone OPV<br>Audit Code   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
| <b>NON-OPV</b><br><div style="border: 1px solid black; width: 100px; height: 20px;"></div> Audit Code (s)  |                    | <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th style="width: 10%;">FED</th> <th style="width: 80%;">REFERRALS</th> <th style="width: 10%;">NFED</th> </tr> </thead> <tbody> <tr><td></td><td>Alcohol</td><td></td></tr> <tr><td></td><td>Dental D E P O S K</td><td></td></tr> <tr><td></td><td>Dermatology</td><td></td></tr> <tr><td></td><td>Emergency</td><td></td></tr> <tr><td></td><td>ENT</td><td></td></tr> <tr><td></td><td>Eye</td><td></td></tr> <tr><td></td><td>General Practice</td><td></td></tr> <tr><td></td><td>GYN/OB</td><td></td></tr> <tr><td></td><td>Internal Medicine</td><td></td></tr> <tr><td></td><td>Mammogram</td><td></td></tr> <tr><td></td><td>Mental Health</td><td></td></tr> <tr><td></td><td>Orthopedics</td><td></td></tr> <tr><td></td><td>Other</td><td></td></tr> <tr><td></td><td>Pediatrics</td><td></td></tr> <tr><td></td><td>Physical Therapy</td><td></td></tr> <tr><td></td><td>Surgery</td><td></td></tr> </tbody> </table>                                    |  | FED   | REFERRALS | NFED |  | Alcohol |  |  | Dental D E P O S K |  |  | Dermatology |  |  | Emergency |  |  | ENT |  |  | Eye |  |  | General Practice |  |  | GYN/OB |  |  | Internal Medicine |  |  | Mammogram |  |  | Mental Health |  |  | Orthopedics |  |  | Other |  |  | Pediatrics |  |  | Physical Therapy |  |  | Surgery |  | <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th colspan="2" style="text-align: center;">TICKLER UPDATE</th> </tr> </thead> <tbody> <tr><td></td><td>Audiogram</td></tr> <tr><td></td><td>PPD/CXR for TBC</td></tr> <tr><td></td><td>HIV</td></tr> <tr><td></td><td>Influenza</td></tr> <tr><td></td><td>Tetanus/Diphtheria</td></tr> <tr><td></td><td>Yellow Fever</td></tr> </tbody> </table> |  | TICKLER UPDATE |  |  | Audiogram |  | PPD/CXR for TBC |  | HIV |  | Influenza |  | Tetanus/Diphtheria |  | Yellow Fever |
| FED  | REFERRALS          | NFED   |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Alcohol            |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Dental D E P O S K |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Dermatology        |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Emergency          |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | ENT                |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Eye                |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | General Practice   |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | GYN/OB             |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Internal Medicine  |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Mammogram          |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Mental Health      |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Orthopedics        |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Other              |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Pediatrics         |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Physical Therapy   |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Surgery            |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
| TICKLER UPDATE   |                    |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Audiogram          |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | PPD/CXR for TBC    |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | HIV                |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Influenza          |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Tetanus/Diphtheria |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  | Yellow Fever       |  |  |   |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |
|  |                    |  |  | <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between;"> <span>Class</span> <span>Dx Minutes</span> <span>PSR Total</span> <span>Biopsy</span> </div> <div style="display: flex; justify-content: space-between;"> <span>1.</span> <span>2.</span> <span>3.</span> </div> |           |      |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |  |                |  |  |           |  |                 |  |     |  |           |  |                    |  |              |

PREVIOUS EDITION MAY BE USED



Figure 6-B-1 (reverse)

### AUDIT CODES

|   |  |
|---|--|
| <b>AG</b> -- Acute Gastroenteritis        | <b>HT</b> -- Hypertension              |
| <b>AV</b> -- Abnormal Vaginal Bleeding    | <b>LB</b> -- Low Back Pain             |
| <b>BA</b> -- Bronchial Asthma             | <b>MS</b> -- Minor Surgery             |
| <b>BM</b> -- Breast Mass                  | <b>OM</b> -- Otitis Media              |
| <b>BS</b> -- Blood in Stool               | <b>PF</b> -- Pediatric Febrile Illness |
| <b>CH</b> -- Cholesterol Problem          | <b>PP</b> -- Pelvic Pain               |
| <b>CP</b> -- Chest Pain                   | <b>PY</b> -- Pyoderma                  |
| <b>DE</b> -- Depression                   | <b>SI</b> -- Sinusitis                 |
| <b>DM</b> -- Diabetes Mellitus            | <b>ST</b> -- Strep Throat              |
| <b>DY</b> -- Dyspepsia                    | <b>TD</b> -- Thyroid Disorder          |
| <b>FP</b> -- Failed Procedure/Retreatment | <b>TM</b> -- TMJ Problem               |
| <b>HA</b> -- Headache                     | <b>UR</b> -- URI                       |
| <b>HE</b> -- Hematuria                    | <b>UT</b> -- Urinary Tract Infection   |
| <b>HI</b> -- Head Injury                  | <b>WC</b> -- Well Child Exam           |
| <b>IP</b> -- Infection-Postop             | <b>WP</b> -- Wisdom Tooth Problem      |

| NEW PATIENT INFORMATION   |  |
|---|--|
| ACTIVE DUTY (All Services) AND CIVILIAN EMPLOYEES   |  |
| <b>SERVICE</b><br>USCG <input type="checkbox"/> USA <input type="checkbox"/> USN <input type="checkbox"/><br>USAF <input type="checkbox"/> USMC <input type="checkbox"/> OTHER <input type="checkbox"/> | <b>UNIT</b><br>_____   |
| <b>ADDRESS</b><br>Street _____<br>City _____<br>State _____ Zip _____   | <b>DEPT/DIVISION</b><br>_____  |
| <b>PHONE</b><br>Home: (    ) _____<br>Work: (    ) _____  | <b>CHECK AS APPROPRIATE</b><br><input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Hearing Conservation Program<br><input type="checkbox"/> Command Afloat<br><input type="checkbox"/> Landing Signal Officer<br><input type="checkbox"/> Civilian Employee<br><input type="checkbox"/> Alert Force<br><input type="checkbox"/> Aviation<br><input type="checkbox"/> OMMP |
| DATE OF BIRTH: _____ Month _____ Year _____   |  |
| <b>DRUGS ALLERGY/REACTION</b><br>1. _____ 2. _____<br>3. _____ 4. _____ 5. _____  |  |

### PRIVACY ACT STATEMENT

1. Authority for collection of the information is Title 5, 10 and 14 United States Code and Executive Order 9397.
2. Principle Purpose(s) for which information is intended to be used is the documentation of your health care. The SSN is required to identify authorized beneficiaries and retrieve health records.
3. The routine uses will be to plan and coordinate future health care needs through the use of data collection.
4. Disclosure of the information is mandatory because of the need to document all active duty medical incidents and for all other personnel/beneficiaries to document their eligibility. If the requested information is not furnished, comprehensive health care will not be possible. Emergency/Urgent health care will not be denied.



Figure 6-B-2

| DEPARTMENT OF<br>TRANSPORTATION<br>U.S. COAST GUARD<br>CG-5460B (Rev. 9-92)  |                           | <b>VISIT PROFILE</b><br><small>See Privacy Act Statement on Page 2</small>  |           | DATE _____<br>Month    Day    Year   |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|--|---------------------------|---|-----------|--|--|-----|-----------|-----|--|---------|--|--|--------------------|--|--|-------------|--|--|-----------|--|--|-----|--|--|-----|--|--|------------------|--|--|--------|--|--|-------------------|--|--|-----------|--|--|---------------|--|--|-------------|--|--|-------|--|--|------------|--|--|------------------|--|--|---------|--|--|-----------|--|-----------------|--|-----|--|-----------|--|--------------------|--|--------------|--|--|--|---------------|--|--|--------------|--|-------------|--|--|-----------|--|-----------------|--|--|--------------|--|----------------|--|--|-----------------|--|---------------|--|--|----------------|--|-----------------|--|--|---------------------|--|-------------|--|--|---------------------------|--|---------------------------|--|--|---------------|--|--------------------|--|--|-----------------|--|---------------|--|--|------------|
| <b>NAME</b><br><br>Last                      First                      MI   |                           | <b>SPONSOR'S SOCIAL SECURITY NUMBER</b><br>____ - ____ - ____   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
| <b>PURPOSE OF VISIT</b>  |                           | <b>SPONSOR'S STATUS</b>   |           | <b>DEPENDENT'S INFO</b>  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  |                           | <input type="checkbox"/> Active Duty<br><input type="checkbox"/> Retired<br><input type="checkbox"/> Reservist<br><input type="checkbox"/> Civilian Employee<br><input type="checkbox"/> Non-Beneficiary  |           | Sponsor: <input type="checkbox"/> Active <input type="checkbox"/> Retired<br><input type="checkbox"/> Spouse<br><input type="checkbox"/> Child (circle birth order) _____<br>1 2 3 4 5 6<br><input type="checkbox"/> Unmarried Former Spouse<br><input type="checkbox"/> Sponsor's Parent/in-Law   |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
| <b>NEW PATIENT'S INFORMATION:</b>  |                           |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
| <b>DATE OF BIRTH</b><br>Month    Day    Year   |                           | <b>SERVICE</b>  |           | <b>ADDRESS</b>   |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
| <b>LIST ANY DRUG ALLERGY OR DRUG REACTION</b><br><br>1. _____ 4. _____<br>2. _____ 5. _____<br>3. _____ 6. _____<br><br>Check what time period you intend to use (any) clinic service(s) in the future.<br><input type="checkbox"/> One time visit<br><input type="checkbox"/> Less than 6 months<br><input type="checkbox"/> More than 6 months |                           | <input type="checkbox"/> USCG<br><input type="checkbox"/> USA<br><input type="checkbox"/> USN<br><input type="checkbox"/> USAF<br><input type="checkbox"/> USMC<br><input type="checkbox"/> OTHER   |           | Street _____<br><br>City _____<br><br>State _____ Zip _____<br><b>PHONE</b> Home ( ) _____<br>Work ( ) _____<br><br>Do you have medical insurance other than CHAMPUS? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  |                           | <b>- CLINIC USE ONLY BELOW THIS LINE -</b>  |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  |                           | <b>MEDICAL OPV(s)</b><br><br>Provider's initials _____<br>Limited Visit (0-15)<br>Intermediate (15-30)<br>Extended (>30)<br>Audit Code (s) _____<br>After Hours OPV<br>Lac Repair/Cast/Splint<br>Biopsy<br>Narrative Summary<br>Pap<br>Telephone OPV<br>Routine Exam<br>Subst/Overseas<br>OMMP Basic Exam<br>Command Afloat<br><b>NON-OPV</b><br>Audit Code (s) _____ |           | <b>ACCIDENT/THIRD PARTY</b><br><input type="checkbox"/> Check if this accident could result in a third party claim.<br><br><table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>FED</th> <th>REFERRALS</th> <th>NFD</th> </tr> </thead> <tbody> <tr><td> </td><td>Alcohol</td><td> </td></tr> <tr><td> </td><td>Dental D E P O S K</td><td> </td></tr> <tr><td> </td><td>Dermatology</td><td> </td></tr> <tr><td> </td><td>Emergency</td><td> </td></tr> <tr><td> </td><td>ENT</td><td> </td></tr> <tr><td> </td><td>Eye</td><td> </td></tr> <tr><td> </td><td>General Practice</td><td> </td></tr> <tr><td> </td><td>GYN/OB</td><td> </td></tr> <tr><td> </td><td>Internal Medicine</td><td> </td></tr> <tr><td> </td><td>Mammogram</td><td> </td></tr> <tr><td> </td><td>Mental Health</td><td> </td></tr> <tr><td> </td><td>Orthopedics</td><td> </td></tr> <tr><td> </td><td>Other</td><td> </td></tr> <tr><td> </td><td>Pediatrics</td><td> </td></tr> <tr><td> </td><td>Physical Therapy</td><td> </td></tr> <tr><td> </td><td>Surgery</td><td> </td></tr> </tbody> </table><br><b>TICKLER UPDATE</b><br><table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td> </td><td>Audiogram</td></tr> <tr><td> </td><td>PPD/CXR for TBC</td></tr> <tr><td> </td><td>HIV</td></tr> <tr><td> </td><td>Influenza</td></tr> <tr><td> </td><td>Tetanus/Diphtheria</td></tr> <tr><td> </td><td>Yellow Fever</td></tr> </tbody> </table> |  | FED | REFERRALS | NFD |  | Alcohol |  |  | Dental D E P O S K |  |  | Dermatology |  |  | Emergency |  |  | ENT |  |  | Eye |  |  | General Practice |  |  | GYN/OB |  |  | Internal Medicine |  |  | Mammogram |  |  | Mental Health |  |  | Orthopedics |  |  | Other |  |  | Pediatrics |  |  | Physical Therapy |  |  | Surgery |  |  | Audiogram |  | PPD/CXR for TBC |  | HIV |  | Influenza |  | Tetanus/Diphtheria |  | Yellow Fever | <b>DENTAL OPV(s)</b><br><br><table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td> </td> <td>OPV Caregiver</td> <td rowspan="2">Class<br/>Ox Minutes<br/>PSR Total<br/>Biopsy</td> </tr> <tr> <td> </td> <td>Prophy Giver</td> </tr> <tr> <td> </td> <td>Annual Exam</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>Emergency</td> </tr> <tr> <td> </td> <td>Restoration (s)</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>Surfaces (s)</td> </tr> <tr> <td> </td> <td>Root Canal (s)</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>Pulpotomy (ies)</td> </tr> <tr> <td> </td> <td>Impaction (s)</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>Extraction (s)</td> </tr> <tr> <td> </td> <td>Other Surg/Quad</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>Non-Surg Perio/Quad</td> </tr> <tr> <td> </td> <td>Sealant (s)</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>Treatment Appliances/Arch</td> </tr> <tr> <td> </td> <td>Denture Partial/Full/Arch</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>Cast Unit (s)</td> </tr> <tr> <td> </td> <td>Acid Etch Unit (s)</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>After Hours OPV</td> </tr> <tr> <td> </td> <td>Telephone OPV</td> <td rowspan="2"> </td> </tr> <tr> <td> </td> <td>Audit Code</td> </tr> </tbody> </table> |  |  | OPV Caregiver | Class<br>Ox Minutes<br>PSR Total<br>Biopsy |  | Prophy Giver |  | Annual Exam |  |  | Emergency |  | Restoration (s) |  |  | Surfaces (s) |  | Root Canal (s) |  |  | Pulpotomy (ies) |  | Impaction (s) |  |  | Extraction (s) |  | Other Surg/Quad |  |  | Non-Surg Perio/Quad |  | Sealant (s) |  |  | Treatment Appliances/Arch |  | Denture Partial/Full/Arch |  |  | Cast Unit (s) |  | Acid Etch Unit (s) |  |  | After Hours OPV |  | Telephone OPV |  |  | Audit Code |
|  |                           | FED   | REFERRALS | NFD  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Alcohol                   |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Dental D E P O S K        |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Dermatology               |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Emergency                 |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | ENT                       |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Eye                       |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | General Practice          |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | GYN/OB                    |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Internal Medicine         |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Mammogram                 |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Mental Health             |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Orthopedics               |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Other                     |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Pediatrics                |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Physical Therapy          |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Surgery                   |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Audiogram                 |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | PPD/CXR for TBC           |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | HIV                       |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Influenza                 |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Tetanus/Diphtheria        |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Yellow Fever              |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | OPV Caregiver             | Class<br>Ox Minutes<br>PSR Total<br>Biopsy  |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Prophy Giver              |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Annual Exam               |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Emergency                 |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Restoration (s)           |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Surfaces (s)              |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Root Canal (s)            |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Pulpotomy (ies)           |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Impaction (s)             |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Extraction (s)            |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Other Surg/Quad           |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Non-Surg Perio/Quad       |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Sealant (s)               |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Treatment Appliances/Arch |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Denture Partial/Full/Arch |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Cast Unit (s)             |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Acid Etch Unit (s)        |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | After Hours OPV           |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Telephone OPV             |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  | Audit Code                |   |           |  |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |
|  |                           |   |           | <b>MISC.</b><br>1. _____<br>2. _____<br>3. _____   |  |     |           |     |  |         |  |  |                    |  |  |             |  |  |           |  |  |     |  |  |     |  |  |                  |  |  |        |  |  |                   |  |  |           |  |  |               |  |  |             |  |  |       |  |  |            |  |  |                  |  |  |         |  |  |           |  |                 |  |     |  |           |  |                    |  |              |  |  |  |               |  |  |              |  |             |  |  |           |  |                 |  |  |              |  |                |  |  |                 |  |               |  |  |                |  |                 |  |  |                     |  |             |  |  |                           |  |                           |  |  |               |  |                    |  |  |                 |  |               |  |  |            |

PREVIOUS EDITION MAY BE USED



Figure 6-B-2 (reverse)

**PRIVACY ACT STATEMENT**

1. Authority for collection of the information is Title 5, 10 and 14 United States Code and Executive Order 9397.
2. Principle Purpose(s) for which information is intended to be used is the documentation of your health care. The SSN is required to identify authorized beneficiaries and retrieve health records.
3. The routine uses will be to plan and coordinate future health care needs through the use of data collection.
4. Disclosure of the information is mandatory because of the need to document all active duty medical incidents and for all other personnel/beneficiaries to document their eligibility. If the requested information is not furnished, comprehensive health care will not be possible. Emergency/Urgent health care will not be denied.

**AUDIT CODES**

|   |  |
|---|--|
| <b>AG</b> -- Acute Gastroenteritis        | <b>HT</b> -- Hypertension              |
| <b>AV</b> -- Abnormal Vaginal Bleeding    | <b>LB</b> -- Low Back Pain             |
| <b>BA</b> -- Bronchial Asthma             | <b>MS</b> -- Minor Surgery             |
| <b>BM</b> -- Breast Mass                  | <b>OM</b> -- Otitis Media              |
| <b>BS</b> -- Blood in Stool               | <b>PF</b> -- Pediatric Febrile Illness |
| <b>CH</b> -- Cholesterol Problem          | <b>PP</b> -- Pelvic Pain               |
| <b>CP</b> -- Chest Pain                   | <b>PY</b> -- Pyoderma                  |
| <b>DE</b> -- Depression                   | <b>SI</b> -- Sinusitis                 |
| <b>DM</b> -- Diabetes Mellitus            | <b>ST</b> -- Strep Throat              |
| <b>DY</b> -- Dyspepsia                    | <b>TD</b> -- Thyroid Disorder          |
| <b>FP</b> -- Failed Procedure/Retreatment | <b>TM</b> -- TMJ Problem               |
| <b>HA</b> -- Headache                     | <b>UR</b> -- URI                       |
| <b>HE</b> -- Hematuria                    | <b>UT</b> -- Urinary Tract Infection   |
| <b>HI</b> -- Head Injury                  | <b>WC</b> -- Well Child Exam           |
| <b>IP</b> -- Infection-Postop             | <b>WP</b> -- Wisdom Tooth Problem      |



Figure 6-B-3

|  |  |        |  |
|--|--|--------|--|
| DEPARTMENT OF<br>TRANSPORTATION<br>U.S. COAST GUARD<br>CG 5211 (REV.1-93)          | <b>U.S. COAST GUARD HEALTH CARE EQUIPMENT REQUEST</b><br><i>(This form may be typed or handwritten.)</i> |        |  |
| <b>A. UNIT INFORMATION:</b> THIS SECTION IS TO BE COMPLETED BY THE REQUESTING UNIT |  |        |  |
| UNIT:  |  | OPFAC: |  |

|                           |                         |                       |
|---------------------------|-------------------------|-----------------------|
| EQUIPMENT TO BE REPLACED: | MANUFACTURER;<br>MODEL: | REPAIR<br>COST: _____ |
| ACQUISITION DATE:         |                         |                       |

|  |  |   |
|--|--|---|
| PLANNED REPLACEMENT <input type="checkbox"/>   | EMERGENCY REPLACEMENT <input type="checkbox"/> | NEW REQUIREMENT <input type="checkbox"/>  |
| SUPPLY SOURCE:   |  |   |
| FEDERAL STOCK SYSTEM <input type="checkbox"/>  | GSA /VA CONTRACT <input type="checkbox"/>      | OPEN MARKET ONLY <input type="checkbox"/> |
| EQUIPMENT REQUESTED:   | MANUFACTURE:<br>MODEL:                         | EQUIPMENT<br>COSTS:<br>_____              |
| ACCESSORIES: 1. _____ 2. _____ 3. _____<br>MODEL: _____<br>SERIES: _____                     | ACCESSORY<br>COST:<br>_____                    |   |
| ARE THERE ANY INSTALLATION COST? YES <input type="checkbox"/> NO <input type="checkbox"/>    |  | INSTALLATION<br>COSTS:<br>_____           |
| ARE THERE ANY UNUSUAL REQUIREMENTS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| MANUFACTURE'S ADDRESS:<br>_____<br>_____<br>_____  |  | TOTAL<br>COST:<br>_____                   |
| POC: _____ TELEPHONE NO: _____   |  |   |

COMMENTS: (IF A REPLACEMENT, EXPLAIN WHY EXISTING EQUIPMENT NO LONGER SATISFIES REQUIREMENTS. IF NEW REQUIREMENT, PROVIDE FULL JUSTIFICATION.)

|                        |      |                                  |       |
|------------------------|------|----------------------------------|-------|
| SIGNATURE OF PREPARER: | DATE | SIGNATURE OF COMMANDING OFFICER: | DATE: |
|------------------------|------|----------------------------------|-------|



Figure 6-B-4 (Reverse)

|  |   |
|--|---|
| <b>B. COMMANDER, MAINTENANCE AND LOGISTICS COMMAND</b> |   |
| MINOR HEALTH CARE EQUIPMENT                            | APPROVED <input type="checkbox"/> DISAPPROVED <input type="checkbox"/>        |
| COMMENTS:  |   |
| SIGNATURE OF APPROVED OFFICER:                         |   |
| DATE:  |   |
| MAJOR HEALTH CARE EQUIPMENT                            | RECOMMENDED <input type="checkbox"/> NOT RECOMMENDED <input type="checkbox"/> |
| COMMENTS:  |   |
| SIGNATURE OF REVIEWING OFFICER:                        |   |
| DATE:  |   |

|                                 |  |
|---------------------------------|--|
| <b>C. COMMANDANT (G-KRM)</b>    | APPROVED <input type="checkbox"/> DISAPPROVED <input type="checkbox"/> |
| COMMENTS:                       |  |
| SIGNATURE OF APPROVING OFFICER: |  |
| DATE:                           |  |



## CHAPTER 9

### HEALTH SERVICES TECHNICIANS ASSIGNED TO INDEPENDENT DUTY

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## CHAPTER 9. HEALTH SERVICES TECHNICIANS ASSIGNED TO INDEPENDENT DUTY

### Section A - Independent Duty Afloat.

1. Introduction. An independent duty health services technician (IDT) is a Health Services Technician (HS) assigned to an afloat unit that has no attached medical officer. Assignment to independent duty is challenging. The role is one of tremendous responsibility and at times can tax even the most experienced HS's skill, knowledge and ability. Along with the increased responsibility and sometimes arduous duty comes the potential for personal satisfaction unsurpassed by any other job assignment.
2. Mission And Responsibilities.
  - a. Mission. The Health Services Technician serving independently is charged with the responsibility for the prevention and control of disease and injury, and the treatment of the sick and injured.
  - b. Responsibilities. The Commanding Officer (CO) is responsible for the health and physical readiness of the crew of the unit. In the absence of a permanently attached Medical Officer (MO) the vessel's Executive Officer (XO) is designated by Coast Guard Regulations as the unit's medical officer. The role of the IDT is to assist the command in maintaining the good health and physical readiness of the crew. To accomplish this responsibility, the IDT must be informed of planned operations and anticipate any operational demands resulting from such operations. To this end, the IDT will consult and advise the Command in all matters with potential to effect crew readiness or the health of personnel. Some of the duties of the IDT include:
    - (1) Assessment and treatment of illness and injury;
    - (2) Prevention of illness and injury through an aggressive environmental health program. Such a program includes inspection of living and working spaces; food service and storage areas and food storage and handling practices; integrated pest management practices; potable water quality surveillance; and recognition and management of communicable diseases;
    - (3) Provision of Health Services training aligned with the needs and mission of the unit;
    - (4) Security and proper use of Health Services supplies, material and property;
    - (5) Supply and logistics to ensure supplies, materials and equipment necessary to carry out the mission of the Health Services Department are obtained and maintained in sufficient quantity and condition to support the unit mission and operation;
    - (6) Health Services Department administration, maintenance and security of health records;
    - (7) Strict adherence to Chapter 2 of this Manual which contains information about general and specific duties of the HS serving independently.



3. Chain Of Command. The IDT will normally be assigned to the Administrative Department and will report directly to the Executive Officer (XO).
4. Operation Of The Health Services Department. The IDT is tasked with a wide variety and high volume of duties and responsibilities. This section sets forth policy and guidelines designed to assist the IDT in carrying out assigned duties and responsibilities.
  - a. Health Services Department Standard Operating Procedure. In order to successfully manage the Health Services Department the IDT must use time management and organizational skills and tools. One such tool is a written Standard Operating Procedure (SOP) for the Health Services Department. The SOP will govern the activity of the IDT and has as its guiding precept the goals and missions of the unit. The SOP will be developed and submitted in written form to the CO for approval via the chain of command. In addition, the SOP will be reviewed at least annually by the IDT, XO and CO. The approved SOP will be kept in the Health Services Department for easy referral. Copies of pertinent sections will be posted as appropriate. The SOP will include:
    - (1) A copy of the IDT's letter of assumption of duties as Health Services Department Representative;
    - (2) A written daily schedule of events for both underway and inport periods;
    - (3) Copies of all letters of designation, assignment, and authority that directly impact upon the IDT or Health Services Department. Examples include those granting "By direction" authority, designation as working Narcotics and Controlled Substances custodian, and assignment of a Designated Medical Officer Advisor (DMOA);
    - (4) A copy of the unit's organizational structure. This document will show graphically the IDT's chain of command;
    - (5) A listing of duties and responsibilities assigned to the IDT and the frequency that they are to be carried out. The listing will include both primary and collateral assigned duties;
    - (6) A listing of all required reports, the format required for submission, the frequency or date required, required routing and required "copy addressees". Incorporation of this information in tabular format provides a quick and easy guide for reference purposes;
    - (7) A water bill, for the safe handling of potable water;
    - (8) A unit instruction or SOP for the management of rape or sexual assault cases. The document must provide policy for Health Services Department action in such cases, names of organizations, points of contact and telephone numbers for local resources as well as contact information for agencies and facilities which must be notified. It must contain a prearranged mechanism for timely completion of a physical examination for the purpose of evidence gathering that meets requirements of all applicable law enforcement agencies. Additionally, it must define limitations that will exist if the unit is underway at the time the incident occurs;



- (9) A unit instruction or SOP for the management of suicide threat or attempt. The document must provide policy for Health Services Department action in such cases, names of organizations, points of contact and telephone numbers for local resources, contact information for agencies and facilities which must be notified as well as a listing of required information, reports or actions.
  - (10) A unit instruction or SOP action required in the event of family violence. The document must provide policy for Health Services Department action in such cases, names of organizations, points of contact and telephone numbers for local resources, contact information for agencies and facilities which must be notified as well as a listing of required information, reports or actions.
- b. Other Necessary Documents. The IDT is an integral part of many unit activities and various unit bills and doctrines require specific action by the IDT. Since these are changed frequently, incorporation of Health Services Department responsibilities contained in these various documents into the Health Services Department SOP is not recommended. Applicable portions should be kept in the Health Services Department for quick reference, however. These include:
- (1) A battle doctrine for the unit.
  - (2) Portions of the unit mass casualty bill pertaining to Health Services Department responsibility;
  - (3) Portions of the unit general emergency bill pertaining to Health Services Department responsibility;
  - (4) Portions of the unit man overboard bill pertaining to Health Services Department responsibility;
  - (5) Portions of the unit replenishment at sea, special sea detail, flight quarters and bomb threat bills pertaining to Health Services Department responsibility.
- c. Departure From the Daily Schedule of Events. The day-to-day operation of the Health Services Department is complex and impacted upon by the operational needs of the unit. It will of necessity change when events of higher priority or concern occur. If deviation from the daily schedule of events is required, notification of the XO (IDT's Division Officer) will be made at the earliest opportunity. When deviation from daily schedule of events occurs frequently, the daily schedule of events will be reviewed and if necessary, changed. Any changes will be incorporated into the Health Services Department SOP and approved by the Commanding Officer.
- d. Relief and Assumption of Duties as the IDT. Proper documentation of the status of the Health Services Department, the condition of its equipment, stores, and records is required at the time of relief and assumption of the duties and responsibilities as the IDT. The process is complex and requires both the incoming and outgoing IDT to jointly perform the following:
- (1) A complete inventory of all medical stores, spaces, and equipment, including durable medical equipment. The Health Services Allowance List Afloat



(COMDTINST M6700.6D series) provides a listing of supplies and the equipment required by each class of vessel.

- (a) A controlled substances inventory must be done. Use direction provided in Chapter 10 of this Manual.
    - (b) A complete inventory of all unit property in custody of the Health Services Department;
  - (2) A review of ongoing actions affecting the status of Health Services, e.g., outstanding requisitions, survey or repairs, and proper documentation of all such transactions;
  - (3) A review of the Health Services Department SOP;
  - (4) A review of the most recent Maintenance and Logistics Command (MLC) Quality Assurance Assistance Survey for the unit. A copy of the survey annotated with any finding of incomplete or uncorrected discrepancies will be included as an enclosure to the letter of relief;
  - (5) A review of crew training files required for Tailored Ships Training Availability (TSTA) evaluation. Paragraph A.6. of this chapter provides a listing of requirements;
  - (6) A review of all health records for completeness and accuracy;
  - (7) A complete health, safety and sanitation inspection of the vessel, to include status of potable water systems (records of bacteriological, halogen content and pH testing), food stores inspections, and berthing and habitability of living and berthing spaces.
- e. Letter of Relief and Assumption of Duties. Upon completion of the Health Services Department review a basic Coast Guard letter will be prepared and submitted by the oncoming IDT via the chain of command and will advise the Commanding Officer of the status of the Health Services Department. A copy of the letter will be forwarded to the cognizant MLC. The letter of Relief and Assumption of Duties will provide the following:
- (1) Date of assumption of duties; a statement that the duties and responsibilities of the IDT have been assumed; and a statement that a thorough review of the Health Services Department has been conducted. Any discrepancies of material or record keeping will be annotated on a copy of the unit's most recent MLC Quality Assurance site survey and this survey submitted as an enclosure to the letter of Relief and Assumption of Duties as IDT for the vessel;
  - (2) Any discrepancies noted upon relief will be handled as a matter of individual command prerogative. Responsibility for correction, adjustment of account or inventory records, action required to replace missing items, as well as any necessary disciplinary action will be determined by the command;



- (3) In cases in which no “on site” relief occurs, all of the preceding action will be completed. The supply officer of the unit will participate in the review process in place of the outgoing IDT.
  - f. Actions Upon Proper Relief. Upon assumption of duties as the unit's IDT, one of the first tasks to complete is a thorough review of all SOPs and department instructions. Check the references, make contact with any listed Points of Contact. If possible, make visits and introductions in person. Find out how each system works and how it is accessed.
5. Providing Health Care Afloat. Provision of health care is undoubtedly the most challenging and rewarding part of the job of an IDT. An IDT bears a tremendous responsibility. This responsibility can never be taken lightly. This section is intended to provide a brief summary of the various facets of providing medical care afloat.
- a. Designated Medical Officer Advisor (DMOA). Each independent HS will be assigned a DMOA in accordance with Chapter 2 of this Manual. Good communication between the IDT and the unit DMOA can eliminate many problems affecting health care delivery to the crew. The IDT will schedule a visit to the DMOA as soon as is practical after reporting aboard. The purpose of the visit is to allow first-hand communication of expectations, support facility requirements, and any unique needs or concerns. Open communication can be maintained through regular visits when practical, or at minimum, regular telephone calls. With regard to provision of direct care, the IDT will seek DMOA or another MO's advice whenever there are questions about a patient's condition or when the following conditions exist:
    - (1) Return to sick call before assigned follow-up because of failure to improve or condition has deteriorated;
    - (2) Member cannot return to full duty status after 72 hours duration because of unresolved illness;
    - (3) Undetermined fever of 102 degrees Fahrenheit or higher (when taken orally) persisting for 48 hours;
    - (4) Fever of 103 degrees Fahrenheit or higher (when taken orally);
    - (5) Unexplained pulse rate above 120 beats per minute;
    - (6) Unexplained respiratory rate above 28 breaths per minute or less than 12 breaths per minute.
    - (7) Depression with suicidal thoughts;
    - (8) Change in mental status;
    - (9) Chest pain or arrhythmia;
    - (10) Unexplained shortness or breath;
    - (11) Rape or sexual assault.



- b. Gender Considerations. Chapter 1.A. of this Manual provides specific direction for health services technicians about patient privacy, same gender attendant requirements, and examination restrictions.
- c. Avoiding Common Problems. Scheduling and obtaining the routine medical care needed by crewmembers during short inport periods can tax the organizational skills of even the most experienced IDT. There are, however, actions that the IDT can take which will enhance the chances of getting the routine appointments needed for all members. Some of these are:
  - (1) Identify the routine medical and dental needs of the crew well in advance of return to port. The vessel's supporting clinic has an established appointment scheduling procedure within which the IDT must work whenever operational schedules allow. Provide requests via message (or other written form as appropriate) for appointment scheduling ahead of "appointment schedule opening" for the inport period whenever possible. Request reply by message prior to the vessel's scheduled return to port. Provide the list of scheduled appointments to division officers and shop chiefs for the purpose of identifying in advance operationally related conflicts or leave. Provide request for any appointment rescheduling or changes by message as soon as possible;
    - (a) When routine medical or dental care is to be made directly to a DOD MTF, the IDT must determine the facility requirements for referral of patients and follow any local procedures.
  - (2) Communicate with the vessel's supporting clinic. Visit the supporting clinic, if practical, as soon as possible after return to port. Discuss the crew's medical and dental needs with the clinic supervisor and DMOA (if located at the facility);
  - (3) Post a listing of appointment dates and times as soon as it becomes available. Provide each division officer and shop chief a listing of the appointments applicable to the division or shop;
  - (4) Hold members accountable to be at their appointed place and time. Provide feedback to division officers and shop chiefs on any appointment failure. Notify XO of more than one failure.



- d. Consultations. During the management of complex or protracted cases, consultations or specialty referral may be necessary. When such services are needed, the IDT will normally make referral to a Coast Guard clinic or in some cases, a Department of Defense medical treatment facility (DoD MTF). When referring a patient to see a medical officer at a CG health services clinic, the IDT shall ensure that a SF-600 entry is completed using the SOAP format and that an appointment is scheduled. The clinic will normally provide treatment or arrange care if treatment is beyond its scope. When consultations or referral for specialty care are made directly to a DOD MTF, the IDT must determine the facility requirements for referral of patients and follow any local procedures. Referrals to a DOD MTF will normally be documented using a Consultation Sheet (SF 513) or a Referral for Civilian Medical Care DD (2161). The consultation will provide a concise history of the condition to be evaluated as well as any pertinent findings. A provisional diagnosis is normally expected by the consultant. Chapter 4 of this Manual provides direction on completion of a SF 513. The patient and the patient's supervisor must be informed of all consultation or referral appointment dates and times. Courtesy is an important part of maintaining good working relationships with the facilities that the independent duty HS accesses for consultation and referral. Timely notification of the referral facility when appointment changes or cancellations occur (along with brief explanation of why the change is required) help maintain those relationships. Whenever possible, provide at least 24 hours notice of changes or cancellations.
- e. Medical Evacuation (MEDEVAC) of Injured or Ill Crewmembers. Medical evacuation must be considered when care needed by a patient to preserve life or limb, provide pain relief beyond capability onboard, or to provide other medical or dental treatment for which delay until the unit's next scheduled port call would provide undue hardship or pain for the patient. The unit's ability to MEDEVAC a patient will be affected by the vessel's current mission, availability of air transport assets, and location. When considering or executing a MEDEVAC:
- (1) Keep the XO informed. At first indication that a MEDEVAC may become necessary, notify the XO;
  - (2) Request, via the XO, communication with the IDT's DMOA, a medical officer familiar with the vessel's current area of operation or a flight surgeon if MEDEVAC is to be by aircraft. In addition to a thorough patient presentation, information about the unit's location in relation to medical resources ashore and realistic estimations of time requirements to reach a point that MEDEVAC is possible, must be available. Keep the XO and the DMOA/medical officer/flight surgeon advised of any change in the patient's condition;
  - (3) Thoroughly document the MEDEVAC process. Ensure that a complete patient record is maintained in the patient's health record. Maintain a complete record of events in the Health Services log. Make entries as events occur. It is very difficult to reconstruct an accurate log entry "after the fact".
  - (4) Keep the patient informed. Explain in as much detail as possible the actions being taken and expected outcome of the actions. As time of departure approaches, describe for the patient what to expect during transport and upon



arrival at destination. If a Coast Guard Beneficiary Representative is attached to the medical facility to which the patient is being MEDEVACed, provide this information to the patient.

- (5) Ensure that all documentation about the patient's condition is contained in the health record and that it and any medication needed by the patient during transport are securely packaged and ready for transport with the patient. Ensure that information necessary for unit contact and contact of the unit's supporting clinic are provided and easily located by the receiving medical facility. Anticipate the patient's need for personal items, including a valid Armed Forces Identification Card, and ensure these are packaged for transport with the patient. Limit such items to those that are necessary. Encourage the patient to limit cash.
  - (6) Notify the unit's supporting clinic of the MEDEVAC and any needed assistance for the patient.
  - (7) Provide an inpatient hospitalization notification message in accordance with current directives. See Chapter 6.A. of this Manual.
- f. Surgical Procedures. Most routine minor surgical procedures will be delayed until the vessel is in port. Surgical procedures while underway will be limited to only those procedures that are needed in order to return a patient to a fit for full duty status. These procedures include:
- (1) Placing and removing sutures in a wound;
  - (2) Incision and drainage;
  - (3) Unguinectomy;
  - (4) Paring down painful plantar warts.
- g. Refusal of Treatment. Medical, dental, and surgical treatment will not be performed on a mentally competent member who does not consent to the recommended procedure except:
- (1) Emergency care is required to preserve the life or health of the member;
  - (2) Isolation and quarantine of suspected or proven communicable diseases as medically indicated or required by law to ensure proper treatment and protection of the member or others.
- h. Motion Sickness. Members that manifest chronic motion sickness, that do not respond to conventional therapy, and are unable to perform their duties as a result, will be considered for administrative separation from active duty as per the Personnel Manual, COMDTINST M1000.6 (series).



- i. Antibiotic Therapy. The IDT may prescribe and administer antibiotics included on the Health Services Allowance List Afloat. Whenever possible, the IDT should consult with his/her DMOA or a medical officer for a recommendation or concurrence prior to administering antibiotic therapy. If consultation is not possible prior to administration a message must be sent to the DMOA providing case history, ICD9CM code and treatment provided.
- j. Health Services Treatment Space. The Health Services treatment space will be manned at all times when patients are inside. All items are to be stowed in their proper place and secured. All medical records shall be locked in a cabinet. At no time should the Health Services space be left unlocked when the IDT is not onboard.
- k. Patient Berthing. Some units have facilities for short term berthing of patients in the Health Services Department. These facilities are provided to facilitate close patient observation or treatment. No person other than the sick or injured will be berthed in the Health Services Department. The IDT may sleep in the Health Services Department when attending an injured or sick patient, but will have a regularly assigned berthing space. Personal gear and clothing are not to be stored in the Health Services Department. The Health Services Department will not be used as berthing spaces for augmented personnel.
- l. Not Fit For Sea Duty. Members who are medically, surgically, or orthopedically unfit for sea duty (including wearing a cast or needing to use crutches), and unable to perform their duties will not be placed onboard the vessel. Personnel will either be placed on Limited Duty ashore or on Convalescent Leave.
- m. Convalescent Leave. Convalescent leave is a period of leave not charged against a member's leave account. It can be a recommendation to the command when a patient is Not Fit For Duty (usually for a duration expected to be greater than 72 hours) and whose recovery time can reasonably be expected to improve by freedom from the confines of quarters. It should be considered only when required as an adjunct to patient treatment. The command must evaluate each recommendation. Commands are authorized to grant convalescent leave as outlined in Chapter 4 of the Personnel Manual.
- n. Controlled Substances. Regulations for the handling, storage, and issue of narcotics and controlled substances are found in Chapter 10 of this Manual. The contents of this section are not intended to contradict the guidance provided there. This section serves to amplify policy provided with respect to medicinal narcotics and controlled substances onboard afloat units.
  - (1) Narcotics and controlled substances require special handling. All controlled substances shall be obtained through the unit's collateral duty pharmacy officer.
  - (2) The CO will designate a commissioned officer as the controlled substances custodian (CSC). The CSC will follow the accounting procedure provided in Chapter 10 of this Manual. The IDT will normally be assigned as custodian for



narcotics and controlled substances working stock. Such assignment must be made in writing.

- (3) All issues from working stock will be documented with a properly completed, written prescription. All non-emergent care requires contact with a medical officer before dispensing any controlled medication. The medical officer's orders will be documented on a prescription and in the patient's health record. The words "By verbal order of" will precede the ordering medical officer's initials, last name, time of order and date of order both on the prescription and in the patient's health record. In the event of a true emergency, a medical officer's order is not needed to dispense a controlled substance. Once the emergency situation is over or alleviated, the IDT will contact a medical officer, detail the circumstances and the controlled substances that were administered. Upon concurrence by the medical officer, the prescription prepared for the patient will be annotated with the words "By concurrence of" the ordering physician's initials, last name, time of concurrence and date of concurrence.
  - (4) The XO will countersign all prescriptions prepared by the IDT prior to issue of any controlled substance or narcotic.
  - (5) Controlled substances stored aboard cutters shall be limited to amounts in the Health Services Allowance List (HSAL). If the need exists for the unit to carry additional quantities of controlled substances based on use or potential for operational need, a written request signed by the Commanding Officer will be forwarded to the unit's cognizant MLC (k). The request must include, nomenclature, quantity, and brief justification.
- o. Dental. It is the duty of the IDT to arrange for the necessary dental examinations of the crew. All personnel should be Class I or Class II prior to deployment.
- (1) All personnel must receive an annual dental exam.
  - (2) The IDT will arrange, usually via message, for the large group of dental appointments needed for crewmembers returning from deployment. A signup sheet and announcement to the crewmembers is advised, and early communication with the staff of the dental clinic is recommended in order to allow sufficient time for the scheduling of a large amount of dental visits. Urgent cases obviously are to be scheduled first, regardless of rank or position of the member. Once back in port, active communication with a designated POC in the dental clinic is advised in order to handle cancellations, substitutions and last minute appointment changes. Although it may be time consuming, it is easier to deliver patient reminders the morning of the scheduled appointment than to try and explain a group of no-show crewmembers to a dental officer or XO.



- p. Rape or Sexual Assault. All victims of rape or sexual assault must be treated in a professional, compassionate and non-judgmental manner. Examination of rape and sexual assault victims will be limited to only visual examination of any wound or injury and treated according to present standards of care. In all cases, a medical officer will be contacted for advice. In the event that no medical officer is available (underway), an IDT may conduct the visual examination. A chaperone of the same gender as the patient will be present if such examination is conducted. All aspects of the patient encounter must be carefully documented. Physical examination to gather evidence of rape or sexual assault is strictly prohibited. Also, see paragraph A.4.a. of this chapter.
- q. Suicide Prevention. An encounter with a suicidal person is always a deeply emotional event. It is important for the IDT to act in a caring and professional manner. Early intervention and good communication skills are essential. If suicidal ideation is suspected it is important to remember:
- (1) Take all threats and symptoms seriously. Immediately seek professional help from the nearest MTF for any member considering suicide. At no time should the person be left unattended;
  - (2) Actively listen to the patient. Do not argue, judge, attempt to diagnose, or analyze the person's true intentions. It is important to provide a calm, caring, professional demeanor throughout the entire situation. Thoroughly document the patient encounter using the SOAP format;
  - (3) Arrange for an escort and a driver to transport the patient to the nearest Coast Guard clinic, MTF or civilian emergency room with facilities appropriate to the situation. The unit's SOP for suicide threat or attempt should contain this information for ready use if needed. If underway, then a MEDEVAC must be considered. An IMARSAT phoncon with a flight surgeon, if MEDEVAC by aircraft is required, the IDT's DMOA or a medical officer familiar with the area of operation is required.
- r. Decedent Affairs. Chapter 5 of this Manual contains guidance about action that the Health Services Department must take when there is a death aboard a Coast Guard unit. Chapter 11 of the Personnel Manual, COMDTINST M1000.6A (series) contains further guidance concerning casualties and decedent affairs, as does the Decedent Affairs Guide, COMDTINST 1770.1C (series). It is unlikely that the IDT will be assigned as the Casualty Assistance Calls Officer (CACO) for the command, but the IDT will undoubtedly be heavily involved with the process of proper disposition of remains, so familiarity with the information required is helpful. The IDT should also perform the following:
- (1) An entry in the Health Services Log will be made detailing all available information concerning the death;
  - (2) The health record of the deceased member will be terminated in accordance with Chapter 4 of this Manual.
- s. Disposition of Remains.



- (1) As soon as possible, remains will be transferred to the nearest Military Treatment Facility (MTF) for further disposition. When transfer cannot be accomplished immediately, the remains will be placed into a body pouch and refrigerated at a temperature of 36 to 40 degrees Fahrenheit to prevent decomposition. The space must contain no other items and must be cleaned and disinfected before reuse. Remains will be identified with a waterproof tag, marked with waterproof ink, and affixed with wire ties to the right great toe of the decedent and also to each end of the body pouch. The minimum information needed on each tag includes the full name, SSN and rate of the decedent. Whenever possible, do not remove items attached to the deceased at time of death. Such items may include (for example) IV lines, needles, lengths of cord or line, etc. These may be important during an autopsy.
    - (a) Additionally, do not discard or launder clothing of the deceased. These items are sometimes important to surviving family members and in some cultures are part of the mourning process for the deceased. This is a cultural consideration but should be a part of the decision process.
- t. Physical Disability Evaluation System. The medical board process is detailed in Chapter 17.A. of the Personnel Manual, COMDTINST M1000. 6A (series) and the Physical Disability Evaluation System, COMDTINST M1850.2 (series).
  - (1) Death Imminent. Chapter 17 A of the Personnel Manual and the Physical Disability Evaluation System Manual describe the actions a unit must take to initiate an expedited review process. The purpose of the expedited review process is to provide a member whose death is imminent, with the counsel to represent the member's best interests, and an opportunity to make timely decisions that will maximize applicable benefits for the member's dependents. The IDT must become familiar with the actions required. As with decedent affairs, the IDT may not have primary responsibility for completing all actions in a death imminent case, but will be required to provide necessary information in a timely manner.
6. Training. The purpose of training provided to the crew of an afloat unit include: assurance that crewmembers are able to provide aid for themselves and their shipmates in an emergency or a combat situation; and to promote the general health and well being of the crew. To this end, a written Health Services Department Training Plan will be prepared and submitted to the unit training officer for incorporation into the unit training plan.



- a. Health Services Department Training Plan. A plan for training of the crew will be established. The plan will be established in written form and kept on file. It will be based on a minimum 12 month cycle and be included in the cutter training schedule. At a minimum, the following training will be given annually:
- (1) Basic first aid;
  - (2) Shock, hemorrhage control, bandaging;
  - (3) Airway management and assisted ventilation;
  - (4) Route to battle dressing stations (BDS), use of items in first aid kits, gunbags and boxes;
  - (5) Personal and dental hygiene;
  - (6) STD/HIV prevention;
  - (7) Heat and cold stress programs, including hypothermia;
  - (8) Respiratory protection program;
  - (9) Hearing conservation;
  - (10) Poisoning;
  - (11) Sight conservation;
  - (12) Blood borne pathogens;
- b. Documentation of Training. Documentation of the training is a TSTA requirement as well as a requirement of several Coast Guard programs. The rule of thumb to remember is “If it isn’t written down, it didn’t happen.” An outline must be prepared and kept on file for all training topics presented and a training log maintained for all training provided. The training log will contain a record of all HS training given to the crew, stretcher-bearers, and HSs. It will contain the following information:
- (1) Date;
  - (2) Topic;
  - (3) Duration;
  - (4) Group or department receiving the training;
  - (5) Instructor’s name;
  - (6) Names (signatures of those present) of members trained.
- c. Training Format. Training will normally be presented in either lecture format or demonstration and practical application. Lecture format presentations should be limited to 15 to 20 minutes and demonstrations and practical application should not exceed 1 hour.
- (1) Practical application must be of high priority in training the crew and stretcher-bearers in first aid, casualty evaluation, treatment, reports to damage control central, and transporting casualties to battle dressing stations. There is no



substitute for "hands on" practice in developing effective first aid and patient transport skills.

- d. Departmental Training. Specific training not applicable to the entire crew, but appropriate to individual departments, should be incorporated into the Health Services Training Plan. Such departmental training is normally needed because of workplace exposure to potential health hazards. Training subjects appropriate to various departments are listed in the following subparagraphs. The list is not all inclusive. It is provided as a guideline.

(1) Weapons department:

- (a) Hearing conservation,
- (b) Heat stress (ship's laundry personnel),
- (c) Respiratory protection,
- (d) Basic life support (fire control personnel),
- (e) Review of prevention and treatment of electric shock casualties,
- (f) Eyesight protection.

(2) Engineering department:

- (a) Hearing conservation,
- (b) Potable water,
- (c) Heat stress,
- (d) Respiratory protection,
- (e) Eyesight protection,
- (f) Hazards associated with human waste.

(3) Supply department:

- (a) Food service sanitation (food service personnel);
- (b) Heat stress (scullery personnel).

(4) Operations department:

- (a) Basic life support (electronics shop personnel),
- (b) Review of prevention and treatment of burns, electric shock and hemorrhage.

(5) Deck department:



- (a) Eyesight protection,
  - (b) Hearing conservation,
  - (c) Heat stress,
  - (d) Respiratory protection.
- e. Drills. Drills are a necessary part of unit training. Drills help to reinforce performance of skills and actions that must be completed during stressful or potentially dangerous situations. Drills that have close relation to health and safety of the crew will be incorporated into the Health Services Department Training Plan. The cutter training board should integrate Health Services Department Training Plan drills into the unit's training schedule.
- (1) The following drills will be conducted semi-annually:
    - (a) Battle dressing station;
    - (b) Personnel casualty transportation;
    - (c) Mass casualty.
  - (2) The following drills, at minimum, will be conducted quarterly:
    - (a) Compound fracture;
    - (b) Sucking chest wound;
    - (c) Abdominal wounds;
    - (d) Amputation;
    - (e) Facial wounds;
    - (f) Electrical shock;
    - (g) Smoke inhalation;
    - (h) Casualty transport.
- f. Training and Assignment of Stretcher-Bearers. No less than four stretcher-bearers will be assigned from each repair locker. The training for stretcher-bearers will include all subjects given to the crew with emphasis on basic first aid, casualty evacuation, triage, use of all stretcher types maintained onboard the unit, casualty carrying methods, Battle Dressing Station (BDS) setup and organization and basic life support. Stretcher-bearers must also complete the advanced first aid portion of the Damage Control Personnel Qualification Standards (DC PQS).



- g. Training for the IDT. Careful study, practice, and concentration on all facets of the Health Services Technician rate are necessary to prepare an HS to be successful as an IDT. In addition to the requirements of the rate, attendance of certain "C" schools is required. These are:

- (1) Air Force Medical Services Craftsman - Independent Duty Medical Technician or Navy Surface Forces Independent Duty Technician;
  - (a) Health Services Technicians that have successfully completed an afloat tour as an HS within five years are exempt from this requirement. Additionally, members that have successfully completed multiple TAD periods afloat as an HS may be considered for waiver of this requirement if in the opinion of his/her Designated Medical Officer (DMO) the member has the skills and experience needed for independent duty. Request for waiver are to be submitted in letter format, through the requesting member's chain of command to Commandant (G-WKH-1). Chapter 3 of the Cutter Training and Qualification Manual, COMDTINST M3502.4 (series) contains information about waiver of requirements.
- (2) Coast Guard Introduction to Environmental Health or Navy Basic Shipboard Series. (Note: This is not required for graduates of Navy Surface Forces Independent Duty Technician.);
- (3) Emergency Medical Technician - Basic Level. IDTs assigned to floating units are required to maintain currency with the National Registry of Emergency Medical Technicians (NREMT) at the Basic level. Short Term Training Requests are to be completed in accordance with the Training and Education Manual, COMDTINST M1500.10(series) and forwarded to Commandant (G-WKH-1). Funding will be provided by Commandant (G-WK). See the Emergency Medical Services Manual, COMDTINST M16135.4 (series) for additional information.

7. Supply And Logistics.

- a. Custody of Health Services Equipment and Material. As directed by the Commanding Officer, the IDT is responsible and accountable for the health services material onboard the cutter. As such, the IDT is the custodian of all health service equipment and material. The custodian will not permit waste or abuse of supplies or equipment and will use techniques such as stock rotation, planned replacement and preventive maintenance to minimize waste of resources.
- b. Inventory. An accurate record of medical stores and equipment must be maintained. The inventory of medical stores, spaces and equipment will be prepared using the Stock Record Card Afloat (NAVSUP Form 1114) or in line item form (computerized database is an approved and preferred alternative if all necessary information is captured) and include:
  - (1) Quantity and shelf-life of each item currently on board;



- (2) Balance on hand, high-level, low-level (reorder point for each item);
  - (3) Manufacturer, lot number and expiration date (pharmaceuticals);
  - (4) Quantity placed on order, date received.
- c. Unit Property. Unit property in Health Services Department custody must also be safeguarded and accounted for. The unit property custodian should be contacted before transfer or destruction of such property.
- d. Funding and Account Record Keeping. Funds used to purchase supplies and equipment, and to pay for the various expenses of operating the unit are broken down into Account Funding Code (AFC) expenditure categories. This method allows for efficient budgeting and accounting. Fund categories generally used by IDTs fall within the AFC subhead 30 or 57 expenditure categories.
- (1) AFC 30 is a general ship fund used by the supply department to purchase generally needed operating supplies and services. Examples include pens, paper, books, training aids, etc. AFC 30 funding can be used to pay for Health Services Department supplies and equipment not obtainable through Defense Supply Center Philadelphia Prime Vendor Program (via the unit's supporting clinic) or the major medical equipment request process (see Chapters 6 and 8 of this Manual). Restrictions exist on what may be purchased with AFC 30 funds. Specific questions can be answered by unit supply personnel.
  - (2) AFC 57 is a funding category used to purchase health care related supplies and equipment, and to pay for health care. AFC 57 funds are distributed to the MLCs and further allocated by them to the units within their areas of responsibility.
  - (3) With the full implementation of the Prime Vendor programs for Pharmaceuticals and for Medical and Surgical Supplies, AFC 57 fund allocations will be made to the Prime Vendor ordering point assigned for the unit.
- e. Budgets and Budgeting. In general, IDTs do not need to plan and submit an AFC 57 budget request because medical supplies and equipment funding are controlled by the MLCs and Prime Vendor ordering points. If additional AFC 57 resource needs are anticipated, the IDT's supporting clinic should be contacted for direction on how the resources are to be requested. The budget build process does have value for the IDT value, however. AFC 30 funds will need to be planned for and requested and medical equipment in need of planned replacement must be identified and CG 5211s submitted. The budget build process is a good way to handle these needs. AFC 30 fund budget planning is relatively straight forward, although it can be time consuming. AFC 30 expenditures for Health Services should be broken into general use categories. Examples of categories are books and publications, non consumable goods and services such as hydro testing and replacement of oxygen cylinders, and travel for continuing education. Budgeting categories can be as simple or complicated as the IDT desires to make it. Once categories have been established, a ledger for the Health Services Department should be "opened" and the expenditure



categories entered into it. The use of a "spreadsheet" program is an efficient way to keep an accounting record but a ledger book works just as well. Attention to detail is the key. In general, a system using four to five categories works well.

- (1) In preparing a budget for the upcoming year, it is important to look back over what was purchased in the previous year. To do this, collect all records of AFC 30 orders and expenditures. Review each line item and record the amount spent into the appropriate budget category. The steps for preparing a budget and carrying it out along with general timelines are contained in this paragraph. They are:



|           |  |
|-----------|--|
| March     | <p>Look back process. Review amount of funds spent over the first two quarters of the fiscal year as well as spending patterns for the previous fiscal year. Note general categories on which funds were spent and in which quarter items were ordered. This will allow projection of quarterly funding needs into the upcoming year.</p>  |
| April/May | <p>Review status of the Health Services Department medical library and determine which texts and references must be updated.</p> <p>Review status of HS certifications and continuing medical education. Funding for training, conferences or seminars not normally funded by AFC 56 funds must be budgeted for as AFC 30 budget line items.</p> <p>Review preventive maintenance records and include cost projections in AFC 30 budget. Prepare and submit CG 5211s for medical equipment to be replaced.</p> <p>Seek guidance from XO on known or planned activities outside normal operations. An example is a yard period (which will require higher than normal supplies of various personal protective equipment (PPE)) or extended deployments in which normal supply is difficult.</p> |
| June      | <p>Submit finalized budget proposal through chain of command. AFC 30 budget information will be added to the unit budget. Be prepared to “defend” the budget request submitted. Documentation of the data gathering process and retrieval of the raw data used to justify the funding requested will likely be required. AFC 56 funds requests will be consolidated by the command and forwarded to the unit’s district, MLC or Area commander, as appropriate.</p>  |

- (2) Careful stewardship, good record keeping and accounting make existing funding and justification for increased funding levels easier.



- f. Obtaining Pharmaceuticals, Medical and Surgical Supplies. Chapter 8-B of this Manual provides policy applicable to the management of Health Services supplies. Prime Vendor programs for both Pharmaceuticals and Medical/Surgical Supplies have been established and it is through these programs that essentially all pharmaceuticals and supplies will be obtained. Medical Prime Vendor Program Implementation within the Coast Guard, COMDTINST M6740.2 (series) provides detailed instruction about this program. From an "afloat" perspective important aspects of the program include:
- (1) Each afloat unit has been assigned a Prime Vendor ordering point for Pharmaceuticals and for Medical/Surgical Supplies. The cognizant MLC (k) assigns the POCs and periodically updates the information. The Prime Vendor ordering point may be different for each of the programs.
  - (2) Funding for both Prime Vendor for Pharmaceuticals and Prime Vendor for Medical/Surgical Supplies is provided to the assigned Prime Vendor ordering point by the cognizant MLC (k).
    - (a) Internal accounting procedures vary among Prime Vendor ordering points. Some have established individual "accounts" for the units they are responsible for while others manage funds from a central account. Regardless of the accounting method used by the Prime Vendor ordering point, the IDT must establish and maintain a system to track expenditures.
  - (3) Prime Vendor ordering points establish pharmaceutical and medical/surgical supply ordering procedures for their assigned units. Pharmaceutical and medical supply items ordered will be those required by the Health Services Allowance List (HSAL) in quantities required for the unit type. Deviation from the HSAL requirements will normally occur only after justification of the need is made by the IDT to the DMOA for the unit. It will be made in writing and kept on file for review during MLC site surveys.
- g. Health Services Supporting Clinic. The supporting clinic for a vessel is the IDT's partner in providing health care for the vessel's crew. Local agreements and resources may be available to allow the supporting clinic to provide a broader range of services to the IDT and the vessel's crew but at a minimum, the following will be provided.
- (1) All supplies and equipment (under \$300.00) listed in the HSAL for the class of vessel and on the HS Core Formulary. The unit no longer receives AFC 57 funding for the operation of the Health Services Department. These funds are provided instead to the vessel's supporting clinic with the intent that the supporting clinic will provide all required items for the IDT to operate the Health Services Department.
  - (2) Assign the IDT a DMOA in writing. The DMOA shall be available for questions about patient care, as well as completing record reviews quarterly.
  - (3) Perform medical boards for the IDT unit as necessary.



- (4) Provide a resource for advice and support in all administrative areas of health care provision to include medical administration; physical examination review (within the approving authority of the Clinic Administrator), health benefits, medical billing and bill payment processing assistance, dental care pharmacy administration, supply and logistics, bio-medical waste management, IDT continuing education, and quality assurance support. Any services provided at the clinic shall be extended to the IDT to the maximum extent possible
- h. Preventive Maintenance of Health Services Equipment. Chapter 8 of this Manual details the preventive maintenance program for Health Services equipment. Chapters 1 and 2 of the Health Services Allowance List Afloat, COMDTINST M6700.6(series) provide guidance on the maintenance of specific items carried onboard ship (i.e. gunbags, portable medical lockers, stokes litter, etc.). An important part of medical readiness is a program of preventive maintenance and planned equipment replacement. Repair and routine replacement part costs should be recorded on side B of NAVMED 6700/3CG (Medical/Dental Equipment Maintenance Record). Capture of this data will allow more accurate forecasting of AFC 30 funding needs for preventive maintenance.
- i. Replacement of Health Care Equipment. Chapters 6 and 8 of this Manual provide direction on how to obtain replacement of healthcare equipment. An effectively managed planned equipment replacement program minimizes repair costs, and avoids loss of critical equipment at unscheduled times. Additionally, used but still serviceable equipment can be used by other facilities by "turn-in and reissue" through the Defense Reutilization Management Office (DRMO). At least annually, normally during the budgeting process, review the preventive maintenance costs for each piece of Health Care equipment. When repair and maintenance costs for the year exceed 50 percent of the current replacement cost of the equipment, then a CG 5211 (U. S. Coast Guard Health Care Equipment Request) should be submitted to the unit's cognizant MLC(k) requesting replacement.
- j. Disposal of Unserviceable or Outdated Medical Material.
  - (1) Equipment and Supplies. The Property Management Manual, COMDTINST M4500.5 (series) provides guidance on when a formal survey is required. In general, a formal survey is not required except when equipment has been lost or stolen. If uncertain about whether or not a formal survey should be done, the unit's supply officer should be consulted.
  - (2) Pharmaceuticals and Medicinals. Destruction of pharmaceuticals and medicinals will rarely be required. Chapter 8.C. of this Manual directs that materials will not be disposed of at sea, rather prepared for destruction and held in a secure area until the vessel's return to port where they can be disposed of in accordance with federal, state and local laws.
    - (a) Prime Vendors provide a partial credit for some materials returned to them. IDTs and supporting clinics will establish local policy for transfer of expired or short shelf-life pharmaceuticals. A transfer and



replacement of pharmaceuticals within 6 months of expiration should be made with the supporting clinic to minimize waste.

- (b) If destruction is required, it will be accomplished in a well-ventilated area. Liquid substances present potential exposure through splash back. At a minimum, splash proof goggles and neoprene rubber gloves will be worn when working with liquid substances that may be absorbed through the skin. The wearing of protective equipment such as a splash apron is also encouraged. Thorough hand washing after the destruction process must be accomplished. Medical material must be disposed of in a manner so as to ensure that the material is rendered non-recoverable for use and harmless to the environment. Destruction is to be complete, to preclude the use of any portion of a pharmaceutical. Chapter 8. C. of this Manual provides detailed information about destruction and disposal of unsuitable medications.
- k. Disposal of Medical Waste. Federal regulation defines how medical waste must be stored and disposed of, and the records that must be kept to document the storage and disposal. The information in the following paragraphs is provided as a general explanation of program requirements rather than an in-depth instruction on handling of medical waste. Medical waste must be classed in one of two categories: potentially infectious or non-infectious waste. In depth guidance about storage, disposal and required record keeping for medical waste can be found in Chapter 13 of this Manual, in Quality Assurance Implementation Guide (QAIG) 16, and in Chapter 6 of the Safety and Environmental Health Manual, COMDTINST M5100.47 (series). An additional source of information is the unit's hazardous material control officer. In general, the disposal and record keeping requirements for the waste depend on the waste category and are:
  - (1) Potentially infectious waste is defined as an agent that may contain pathogens that may cause disease in a susceptible host. Used needles, scalpel blades, ("sharps"), syringes, soiled dressings, sponges, drapes and surgical gloves will generate the majority of potentially infectious waste. Potentially infectious waste (other than sharps) will be double bagged in biohazard bags, autoclaved if possible and stored in a secure area until disposed of ashore;
  - (2) Used sharps will be collected in an autoclavable "sharps" container and retained on board for disposal ashore. "Sharps" will not be clipped. Needles will not be recapped;
  - (3) An adequate supply of storage and disposal material (containers, bags, etc.,) must be maintained on board to ensure availability even on a long or unexpected deployment;
  - (4) A medical bio-hazardous waste log must be establish and maintained, and must be kept on file for a period of 5 years. A medical bio-hazardous waste log must include the following information:
    - (a) Date of entry;



- (b) Type of waste;
  - (c) Amount (in weight or volume);
  - (d) Storage location;
  - (e) Method of disposal;
  - (f) Identification number (if required by the state regulating authority). If such a number is required, the authority will provide it;
- (5) Non-infectious waste includes disposable medical supplies that do not fall into hazardous waste. Non-infectious waste will be treated as general waste and does not require autoclaving or special handling. It should be placed into an appropriate receptacle and discarded with other general waste.

8. Health Services Department Administration.

- a. Required Reports, Logs, and Records. Clear, accurate record keeping is of paramount importance for the IDT. The quality of care provided to the unit's crew is reflected in the thoroughness of record and log entries completed by the IDT. During compliance inspections, TSTA and customer assistance visits, the IDT and the unit will be evaluated at least in part on the accuracy and completeness of the reports and records created and maintained by the IDT.
- b. The following records will be maintained in the Health Services Department. They will be in book/log form and in sufficient detail, to serve as a complete and permanent historical record for actions, incidents and data.
  - (1) Health Services Log. A Health Services Department log will be maintained by the IDT. This log is a legal document. Entries will be clearly written in a concise, professional manner. The log may be either hand written or prepared using a typewriter or word processor but must be kept on file in "hard copy" form. It is used to document the daily operation of the Health Services Department. Chapter 6.B.8. of this Manual provides the requirement for this log. At a minimum, it will contain the names of all individuals reporting to sickcall for treatment, inspections, inventories conducted, and the results of potable water testing. The log will be signed daily by the IDT and submitted for review, approval and signature on a schedule to be determined by the Commanding Officer. It is worth noting that the Health Services Log will provide the information used in the Binnacle List (see required reports in this Chapter and Chapter 6 of this Manual), so a complete record containing information required in the binnacle list as well as other information of interest will streamline preparation of the report.
    - (a) Training Log. See "Training" in this chapter.
    - (b) Potable Water Quality Log. This log will document the date, location and results of free available Chlorine residual or Bromine testing and



bacteriological testing. Such logs will be maintained in chronological order, record the date and time of test, type of test, collection site, and results of testing. Potable water quality logs must be kept onboard for 2 years. A sample Potable Water Quality Log is available for local reproduction in Chapter 1, Appendix 1.A of the Water Supply and Waste Water Disposal Manual, COMDTINST M6240.5 (series).

- (c) Biohazard waste log. This log will contain information as provided in Chapter 13 of this Manual. Chapter 6 of the Safety and Environmental Health Manual, COMDTINST M5100.47 (series) also provides information and guidance on record retention.
  - (d) Health Records. Health records will be maintained as outlined in Chapter 4 of this Manual. They will be checked for accuracy as outlined in Chapter 4 of this Manual. Navmed 6150/7 Health Record Receipt Form will be used whenever a Health Record leaves the custody of the IDT. A quarterly check using the unit's alpha roster will ensure that any oversight is identified in a reasonably timely manner. All records checked out and not returned shall be reported to the command. In the event of Abandon Ship, make necessary arrangements to salvage health records, if possible. Salvaging health records will be secondary to treating and evacuating casualties.
- (2) Required reports. Numerous reports are required at various intervals. A brief explanation along with a reference is provided for those not mentioned elsewhere in this chapter. Additionally, the information is provided in tabular format at the end of this section.
- (a) Binnacle List. The binnacle list is normally a part of the Health Services Department Log. It is a listing of the names of the members provided treatment, and the duty status determination resulting from the treatment. The list must be kept daily and submitted to the command for review as directed by the CO. It is normally reviewed each week by the XO and signed by the CO.



- (b) Injury Reports. See paragraph 10.a.(16) of this chapter.
- (c) Disease Alert Reports. See Chapter 7 of this Manual for requirements.
- (d) Inpatient Hospitalization Report. See paragraph 5.e. of this Chapter and Chapter 6.A. of this Manual
- (e) Food Service Sanitation Inspection Report. See the Food Service Sanitation Manual and paragraph 10.a.(2) of this chapter.
- (f) Potable Water Quality Discrepancy Report. Required by chapter 1-K.6 of the Water Supply and Waste Water Disposal Manual, COMDTINST M6240.5 (series) when potable water quality fails to meet requirements or is suspect.

Reports Required Weekly

| Report Name                                  | Format or Form Required | Reference                               | Frequency or Date   |
|--|-------------------------|---|---|
| Binnacle List                                | locally designed form   | COMDTINST M6000.1(series)<br>Chap 6.B.8 | Compiled daily, submitted weekly (or as directed by command). |
| Food Service Establishment Inspection Report | CG 5145                 | COMDTINST M6240.4(series)<br>Chap 11.   |   |



### Reports Required Quarterly

| Report Name                           | Format or Form Required   | Reference                    | Frequency or Date                        |
|---------------------------------------|---|------------------------------|--|
| Controlled Substances Inventory Board | Perpetual Inventory of Narcotics, Alcohol and Controlled Drugs, NAVMED 6710/5 | Chapter 10.B. of this Manual | 5 <sup>th</sup> working day of the month |

### Reports Required "As Needed"

| Report Name  | Format or Form Required | Reference   | Frequency or Date   |
|--|-------------------------|---|---|
| Injury Report for Not Misconduct and In-Line-of-Duty Determination | CG-3822                 | See paragraph 10.a.( 16) of this chapter                | As needed. See paragraph 10.a.( 16) of this chapter                 |
| Disease Alert Reports  | RCN 6000-4              | See chapter 7.B. of this Manual                         | As needed   |
| Inpatient Hospitalization Report                                   | Message format          | See chapter 6.A. of this Manual                         | As needed   |
| Report of Potential Third Party Liability                          | CG 4889                 | COMDTINST 6010.16 (series) and chapter 6 of this Manual | As needed   |
| Potable Water Quality Discrepancy Report                           |                         | COMDTINST M6240.5 (series)                              | when potable water quality fails to meet requirements or is suspect |
| Emergency Medical Treatment Report                                 | CG 5214                 | COMDTINST M16135.4 (series)                             | As needed   |



9. Combat Operations .

- a. Battle Dressing Station (BDS). The Health Services Allowance List contains a list of all items required in the BDS, provides information about required frequency of inventory and documentation.
- b. Route and Access Marking to the BDS. On cutters that have a BDS, the routes to the BDS shall be marked in accordance with the Coatings and Color Manual, COMDTINST M10360.3(series). In general:
  - (1) Self adhering Red Cross decals in both photo-luminescence (internal) and nonphoto-luminescence (exterior marking) are authorized;
  - (2) When establishing and marking the routes to the various stations throughout the cutter, the markers shall be located frequently enough to enable the person following the route to have a clear view of the next marker of the route to be followed;
    - (a) On the interior surfaces of the cutter, the signs shall be placed not less than 12 inches above the deck and no higher than 36 inches above the deck. On exterior surfaces, signs shall be placed approximately 60 inches above the deck.
  - (3) Label plates with red letters will be installed at each direct access to BDS;
  - (4) An adhesive reflective marking system will be used and maintained. The purpose of this system is to provide emergency information during a situation involving the loss of lighting.
- c. Use of BDS. On cutters with separate BDSs, the BDS is not to be used for any purpose other than the treatment of injured personnel in an emergency situation. No items are to be placed in a manner which will block access or restrict use of the BDS.
- d. First Aid Kits, Gun Bags and Portable Medical Lockers.
  - (1) Supplies stored in emergency medical kits (first aid kits, gun bags, and portable medical lockers) must be protected from weather and pilferage, and will be maintained as directed in the Health Services Allowance List. An inventory list for each kit will be maintained and a monthly inspection of all first aid kits, gun bags and portable medical lockers will be performed by the IDT. Each kit will be secured with a wire seal or other anti-pilferage device that will indicate when it has been accessed. Each kit will be inspected for tampering (seal intact). The inspection will be noted in the Health Services Log. Once per quarter, the contents of all first aid kits, gun bags and portable medical lockers will be inventoried. The inspection will be noted in the Health Services Log.
  - (2) Antidote locker. A separate poison control locker, marked with a red cross and the words "ANTIDOTE LOCKER" will be prominently located immediately outside the sickbay for ready access by the crew.



- (a) The antidote locker will be secured with a wire seal or other anti-pilferage device that will indicate when the locker has been accessed.
    - (b) An alphabetical inventory, listing the contents and shelf location, will be posted on the inside of the locker. The telephone number of the local poison control center will also be displayed.
    - (c) The antidote locker will be inspected monthly by the IDT and the results will be recorded on the inventory list and in the Health Services Log.
  - e. Oxygen Cylinders. Ensure that oxygen handling and storage precautions are posted next to all oxygen cylinders onboard the vessel. Oxygen is considered a drug and under no circumstances will oxygen be used for any purpose other than patient care. Oxygen cylinders (for ready use) must have the content level read every morning by the HS in order to ensure readiness in case of an emergency. Empty cylinders will be clearly tagged as empty and stored separately from full cylinders. Oxygen cylinders must be hydrostatically tested every 5 years. Damage Control Department personnel will be a good source of information on where to have Oxygen cylinders refilled or hydrostatically tested. Oxygen for medical use must be grade D.
10. Environmental Health. Environmental health program related activities make up a large percentage of the daily responsibility of the IDT. The link between environmental health and mission accomplishment cannot be over-emphasized. From a military perspective, environmental health and environmental health related problems accounted for almost eighty percent of personnel losses during past conflicts in which the United States was involved. For the purposes of this chapter, environmental health encompasses the disciplines of preventive medicine, sanitation and occupational health.
- a. Environmental Health Program Components. An effective environmental health program requires the IDT to have a working knowledge of a large number of unit systems and work processes. An aggressive program of inspection and observation is required. These include:
    - (1) Environmental Health Inspection.
      - (a) The IDT will make routine daily messing and berthing space "walk through" and make note of any conditions that require immediate action. These "walk through" should be done in an informal manner but items requiring correction will be brought to the attention of the department head responsible for the berthing area.
    - (2) Food Service Sanitation. The Food Service Sanitation Manual, COMDTINST M6240.4 (series) provides in-depth information regarding food service sanitation. This section is intended to provide information specific to the duties of an IDT on an afloat unit. In general, the IDT will monitor the food service operation to ensure the protection of the crew from food borne illnesses. The duties of the IDT will include:



- (a) Maintain sanitary oversight of the galley and all food service, preparation, storage and scullery spaces. Such oversight includes stores on-load, storage, preparation, and serving of food; disposal of garbage; proper cleaning and sanitizing of equipment and utensils; personal hygiene of food handlers; proper storage temperature of food products, and the condition and cleanliness of the spaces;
  - (b) Food service areas will be inspected weekly and the findings will be reported on a Food Services Establishment Inspection Report (CG-5145);
  - (c) Conduct an inspection of the subsistence items and food for fitness for human consumption. Ensure that subsistence items were received from sources approved by the U.S. Department of Agriculture (USDA) or an approved source from a foreign port that complies with all laws relating to food and food labeling;
  - (d) Conduct an initial physical screening of food services personnel for detection of any condition or communicable disease that could result in transmission of disease or food borne illness.
- (3) Storage of Food Items. Proper storage procedures play a major part in preventing food borne illnesses. The IDT will make routine inspections of food storage areas to ensure that spaces are properly maintained to prevent supplies from being:
- (a) Infested by insects and rodents;
  - (b) Contaminated by sewage, chemicals, or dirt;
- (4) Subsistence items will be inspected by the HS upon receipt to determine food quality and ensure the stores are free from insect or rodent infestation. The results of this inspection will be recorded in the Health Services Log.
- (5) Coffee Mess. Food consumption, with the exception of coffee and condiments, will be limited to messing areas and lounges. Coffee messes provide a potential food source for insects and rodents if they are not properly located and kept scrupulously clean. For these reasons, permission to establish a coffee mess must be obtained from the Commanding Officer by the department desiring to establish a mess prior to its establishment. Messes will be physically located in a place that can be easily cleaned. Food contact areas (surrounding counter or table tops) must be non porous and kept free of spillage and food debris. Strict sanitary measures are to be used. Coffee mess regulations specifying sanitary operation of the mess will be posted. Use of community cups and spoons are prohibited. Inspection of coffee messes may be documented using a Food Service Sanitation Inspection Report (CG 5145) or through a locally generated inspection report forms.
- (6) Water Supply. Water is used by all members of ship's company and so a tremendous potential exists for ship wide illness should potable water not be



properly loaded from sources free from contamination, protected from contamination onboard, and a halogen residual maintained in the potable water tanks and throughout the distribution system. The IDT will be notified whenever the potable water distribution system is opened for maintenance or repair. Establishment of a working relationship with the ship's engineering company, and the "water king" will aid the IDT in maintaining a proactive stance in regard to prevention of contamination of the vessel's potable water. The IDT will make a monthly inspection of the potable water system and report conditions with potential to affect the health of the crew to the Commanding Officer.

- (7) Halogen Residual Testing. Chlorine/Bromine residual testing will be performed before receiving any water onboard, and also about 30 minutes after an initial halogenation has been accomplished. A water log shall be kept and the results of the daily halogen testing recorded in it. The Color Comparator Test set is used for determining Halogen and pH levels. Nomenclature and ordering information is available in the HSAL. Four test sites should be selected: forward, aft, amidships and as far above the 0-1 deck as possible. This will give the widest range of sample points. Lack of a residual or a residual reading that is significantly lower than results at the other locations indicate possible contamination. Systematic testing from areas with low residuals "backward" to areas with "average" residuals will help locate the source or general area of contamination.
- (8) Bacteriological Test of Water. At least weekly, potable water samples for bacteriological analysis will be collected from two of the four test sites selected for halogen residual testing, as well as a sample collected directly from the potable water tanks. At least weekly, samples of ice must also be collected from any machines making ice used for human consumption and tested for bacteriological growth. The results of bacteriological testing will be entered into the Potable Water Quality Log.
- (9) Habitability. The need for sanitary and hygienic living and working spaces is essential for good health and morale of the crew. General guidance on habitability standards can be found in Chapter 2 of NAVMED P-5010 (series). Habitability inspection can most easily be accomplished if it is made a part of the material inspection of all ship's spaces normally scheduled by each command
- (10) Barber Shops. Any space used for cutting hair may be designated a Barber Shop by the command. It will not be located in food service areas or berthing areas. Sanitation inspection of the ship's barber shop will be performed on a schedule determined by the command. General guidance on standards can be found in Chapter 2 of NAVMED P-5010 (series).
- (11) Ship's Laundry. Laundry spaces will be maintained in a clean and sanitary condition. Because of the potential for elevated temperature and high humidity within the space when laundry equipment is in operation, the ship's laundry will be identified as a heat stress monitoring space and monitored accordingly.



Sanitation inspection of the ship's laundry will be performed on a schedule determined by the command. General guidance on standards can be found in Chapter 2 of NAVMED P-5010 (series).

- (12) Fitness and Exercise Facilities. The fitness and exercise facility will be inspected for cleanliness and compliance with general sanitation standards on a schedule determined by the command. General guidance on standards can be found in Chapter 2 of NAVMED P-5010 (series).
- (13) Insect Control. Roaches, stored product pests, and to a lesser degree flies, can have significant impact on the health and general morale of a ship's company. Insect control starts in the warehouse from which stores are received. When practical, a visit by the IDT to assess storage conditions can help decrease numbers of pests brought on board. Dockside inspection of all food stores brought on board is a must if insects are to be excluded. Produce with "loose" husks or skin such as onions provide common harborage for roaches as does the corrugation of cardboard boxes. Careful inspection with a good light and adjuncts such as an aerosolized flushing agent can identify harborages from which cans and stores can be removed prior to their being brought aboard.
  - (a) Roach Control. A ship provides myriad harborages for roaches. Frequent and regular surveillance by the IDT using a good light and a flushing agent can pinpoint areas of infestation. Roach traps containing pheromones work well in areas with small or isolated infestations. Larger or more widespread areas must be controlled initially with insecticide. Insecticide application will be made only by HSs that hold current certification to apply pesticides. Such personnel have been properly trained in pesticide selection, application, safety and handling precautions. This training is available through Navy Environmental Preventive Medicine Units (NEPMU)s. Pesticide application may be available through Coast Guard Integrated Support Commands with attached Preventive Medicine Technicians. Any insect surveillance activity, general report of findings, or pesticide application, will be reported in the Health Services Log. Pest control services may also be contracted for from civilian pest control firms. Such services are paid for from ships AFC 30 funds and are contracted in the same manner as any other contract for services. While proper selection and application of the materials used is the legal responsibility of the licensed pest control operator, the IDT must be informed of all applications made. The contractor must provide a report of pest control operations which includes, trade and chemical name of product used, strength and formulation applied, type of application (crack and crevice, etc.,) location of application. Requirement for such a report will be included in the contract for services. Report of pest control operations will be held on file for 3 years.
  - (b) Stored Products Pests. A relatively small infestation of flour, grains, beans and cereals with stored products pests can spread quickly and lead



to the loss of most or all of such products in a storage area if an infestation is not identified quickly and action taken to control it. In general, such action consists of identifying infested or suspect lots, removing them from storage with other food stuffs with the potential to become infested, and application of pesticide to control flying insects. Underway, control is limited to identification of infested or suspect lots and their removal.

(14) Rodent Control.

- (a) Exclusion is by far the most effective means of rodent control available to the IDT. Proper installation of rat guards is required on all mooring and service lines when the vessel is in port. Information about proper installation of rat guards can be found in Chapter 8 of the Manual of Naval Preventive Medicine (NAVMED P-5010) and in the Safety and Environmental Health Manual, COMDTINST M5100.47(series). The IDT will inspect all mooring and service lines upon arrival in any port, including home port, to verify the proper placement of rat guards on all of the lines.
- (b) In the event that rodents do gain access to the vessel, an aggressive campaign using traps and/or poisoned bait (if the IDT has been properly trained to apply and use such substances) must be undertaken. Trapping is the preferred method. Assistance may be available from Coast Guard Integrated Support Commands with attached Preventive Medicine Technicians or through the cognizant MLC (k).
- (c) A current deraterization exemption certificate (CDC 75.5(F.4.452)) must be kept onboard at all times. The certificate may be obtained from Coast Guard Integrated Support Commands with attached Preventive Medicine Technicians; Navy units or bases with attached Preventive Medicine Technicians or NEPMUs. The deraterization certificate must be renewed every 6 months, and must be included as a pre-deployment checklist item.

(15) Immunizations and Prophylaxis. The IDT will ensure that all personnel receive required immunizations in accordance with the Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series). MLCs (k) and NEPMUs can provide up to date information on immunization requirements, disease intelligence and preventive medicine precautions required for vessels deploying to OUTCONUS ports.

(16) Safety. A ship is a very dangerous place and dangers inherent to the shipboard environment are heightened by worker's lack of attention, short-cuts, "horseplay," inadequate training or understanding of a job or process, fatigue or over-familiarity. The IDT must remain vigilant in regard to the safety and safe work practices of the crew. A safe work environment can't be maintained from the Health Services Department space. The IDT must become familiar with



the work processes that are on-going and be able to recognize when they are not being done in the proper manner or with the proper materials.

- (a) Mishap Reporting. When accidents or mishaps do occur, certain reports or action may be required. The Safety and Environmental Health Manual, COMDTINST M5100.47 (series) contains requirements and guidance about mishap reporting. Such reports are not normally completed by the IDT, but input may be required regarding severity of injury and required treatment.
  - (b) Accident Reports. The Administrative Investigations Manual, (AIM) COMDTINST 5830.1 (series) contains a requirement that an Injury Report for Not Misconduct and In-Line-of-Duty Determination (CG-3822) be completed whenever an injury results in temporary or permanent disability. This report is referred to in the Physical Disability Evaluation System, COMDTINST M1850.2(series) as an "Line of Duty (LOD) Report" and requirement is made that it be completed for all initial medical boards involving or resulting from trauma. Since it is difficult to determine the outcome of a serious injury in the early stages of treatment, a CG-3822 (also commonly known as an "Accident Report") is usually completed in such cases. It is not necessary to complete an "Accident Report" for any and all injuries unless command policy dictates otherwise.
  - (c) Vessel's Safety Board. The IDT is a required member of the vessel's Safety Board. The IDT should strive to be an active participant in the board, to identify potential problems or accident trends, and suggest solutions to current or potential safety problems. Be proactive. Educate supervisors whenever possible.
- (17) Hazard Communication. The Hazard Communication Program is a unit wide program. Each unit will have appointed a Hazardous Materials Control Officer with overall responsibility for carrying out the program. The Safety and Environmental Health Manual, COMDTINST M5100.47(series)and Hazard Communication for Workplace Materials, COMDTINST 6260.21(series) contain in-depth information about this program. The IDT must be aware of the program requirements and its impact upon the operation of the Health Services Department. Additionally, the IDT must know the location of the unit's central MSDS file and have immediate access to product information which may be needed to render proper treatment to exposed crewmembers. Computerized databases available on CD-ROM are acceptable for this purpose if the Health Services Department contains appropriate access to the information.
- (18) Heat Stress Program. Coast Guard Cutter Heat Stress Program, COMDTINST M6260.17(series) provides details about this program. All areas of the vessel that expose crewmembers to extreme heat will have a dry bulb thermometer



installed. Such areas normally include (but are not limited to) ship's laundry, scullery and engine room spaces.

- (a) Wet Bulb Globe Thermometer (WGBT). A WGBT apparatus must be used to determine stay times of personnel working within heat hazardous spaces or areas and so familiarity with this equipment is required. The apparatus is normally operated by the IDT or member of the engineering department. Recommendations for safe work rest cycles will be provided by the IDT to the Engineering Watch Officer (EWO). Coast Guard Cutter Heat Stress Program, COMDT M 6260.17(series) provides information about the program. The WGBT is listed on the Health Services Allowance List (HSAL) and is procured as health care equipment. A CG 5211 (U. S. Coast Guard Health Care Equipment Request) should be submitted to the unit's cognizant MLC (k). Current calibration of the ship's WGBT apparatus is a TSTA "critical" item. Delinquent calibration can result in cancellation of some or all TSTA drills by the training evaluation team. Contact the cognizant MLC (k) for locations to send WGBTs for calibration.
- (19) Sight Conservation Program. Eye protection and safety should be stressed in the workplace. Safety glasses or goggles will be provided for all crewmembers involved in eye-hazardous tasks. Tools with strong potential for eye hazard will be identified with an adhesive warning label. Fixed machinery with eye hazard potential will have posted nearby an easily visible warning placard, and eye protection will be easily accessible and clearly visible.
- (20) Eyewash Stations. Eyewash stations will be located in any space or work area with strong potential for splashes to, or foreign body injury of the eye. Eyewash stations will be maintained in accordance with the station's manufacturer requirements. Eyewash stations shall be flushed weekly for 15 seconds and flushed and drained according to the recommendations of the biostat ingredient manufacturer used in the station. This interval is usually every six months. Eyewash stations will be "tagged" with a maintenance record tag and inspection or maintenance activities will be recorded when performed. Inspections of eyewash stations will be recorded in the Health Services Log.



## CHAPTER 12

### OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

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## CHAPTER 12. OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

### Section A - General Requirements.

#### 1. Description.

- a. The work environment and occupational activities inherent to Coast Guard missions can expose personnel to health hazards with the potential for disease or injury. The Occupational Medical Surveillance and Evaluation Program (OMSEP) is designed to identify work related diseases or conditions, through baseline and periodic examinations, at a stage when modifying the exposure or providing medical intervention could potentially arrest disease progression or prevent recurrences. The fundamental purpose of this program is to identify pre-existing health conditions, provide risk specific periodic screenings, and monitor clinical laboratory tests and biologic functions suggestive of work related environmental exposures. All OMSEP enrollees receive periodic physical examinations, in accordance with Occupational Safety and Health Administration (OSHA) requirements, for the duration of their health hazard exposure or end of their employment. Individuals are released from active surveillance at the end of their exposure. In accordance with OSHA regulations, the OMSEP personnel tracking database containing the name, social security number, billet or occupation code, applicable examination protocols, and next physical examination due date remains active for an additional 30 years.
- b. The OMSEP is the physical examination process for the Coast Guard's Occupational Health Program. The guidance for this program is outlined in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series). OMSEP replaces the present version of the physical exam process described in the SEH Manual as the Occupational Medical Monitoring Program (OMMP).

#### 2. Enrollment.

- a. Coast Guard Medical Surveillance Action Level: The medical surveillance action level (MSAL) is the level of worker exposure, determined by workplace sampling, at or above which occupational medical surveillance examinations will be performed. The Coast Guard MSAL will be 50% of the most stringent of the current OSHA permissible exposure limit (PEL), or, the most current American Conference of Governmental Hygienists (ACGIH) Threshold Limit Value (TLV).
- b. Determination of Occupational Exposure.
  - (1) An employee is considered occupationally exposed for OMSEP purposes if a noise exposure or hazardous condition is likely to occur **30 or more days per year**. Documentation of the exposure must meet the following criteria: quantitative work-site sampling measurements indicate hazard levels at or above the MSAL or that the exposure can reasonably be determined, in the absence of quantitative sampling, to exceed the MSAL.
  - (2) Quantitative sampling is the primary and definitive means to characterize workplace health hazards, although personal sampling measurement is preferred to workplace sampling. Coast Guard Safety and Environmental Health Officers



(SEHOs) using guidance contained in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series) will generally perform this function. SEHOs will normally characterize workplaces by frequency of exposure, type of exposure, and risk groups.

- (3) Certain occupations or exposures may require surveillance by federal statutes, DOT regulations, or Safety and Environmental Health Manual, COMDTINST M5100.47 (series) without regard to the 30-day exposure threshold.
- (4) Competent environmental health authority is considered to be the cognizant SEHO but the authority may be delegated to other recognized and approved personnel with the necessary technical training and abilities. Qualitative assessments must be based on expected type, frequency, mode, and duration of hazard exposure, and are considered temporary until validated by quantitative means.

c. Enrollment Criteria: Recommendations for enrollment are based on specific job assignments and the level of worker exposure. This process is initiated at the unit level and must be finalized by the IH or cognizant SEHO, with recommendations from the supervising medical officer (if necessary), before forwarding to Maintenance and Logistics Command (MLC (k)) for inclusion into the OMSEP database (see section 12-A-3-(a)-3). This centralized database will be maintained by MLC (k) and will be accessible to the commands in accordance with privacy act requirements. Personnel will be enrolled in the OMSEP if both of the following criteria are met:

- (1) Personnel identified as occupationally at risk/exposed to hazardous chemicals or physical agents at levels documented or reasonably determined to be above the CG Medical Surveillance Action Level (MSAL) for that hazard,
- (2) Personnel actively engaged for 30 or more days per calendar year in the following occupations will be enrolled in OMSEP, unless an IH investigation determines individuals are not exposed to toxic chemicals or physical hazards: resident inspectors, pollution investigators, marine safety (general), port safety (general), vessel inspectors or marine investigators; and fire fighters.

### 3. Reporting Requirements.

#### a. Examination Reports:

- (1) Required forms: OMSEP physical examinations require completion of the most current version of CG Form 5447 (6-00) in addition to forms SF88 and 93. Other OMSEP specific forms and their uses are presented in Section 12-B (also see Table 12-B-1.) Uses of routine medical record forms are presented in Chapter 4 of this Manual.
- (2) Record keeping: OMSEP personnel records will be handled in the same manner as other medical records (see Chapter 4 of this Manual) with the following exceptions: all x-ray, laboratory test, and related reports of examinations or procedures done for OMSEP purposes, as well as the medical record cover, shall be clearly labeled "OMSEP." All OMSEP examination reports, including all laboratory data, must be entered into the individual's health record and maintained in accordance with OSHA regulations. The member's medical record custodian will maintain all OMSEP medical records on file for the duration of employment. Upon separation or retirement, all records concurrently labeled "OMSEP" will be



maintained, for an additional 30 years, as required by OSHA regulations [29 CFR 1915.1120].

- (3) OMSEP database: MLC (k)'s will maintain an electronic database of all OMSEP enrollees based on enrollment information provided by the local units. The OMSEP personnel tracking database should include, at a minimum, the member's name, social security number (SSN), billet or occupation code, applicable examination protocols, and next physical examination due date. The handling of all data in the OMSEP database will comply with Privacy Act requirements.
  - (4) Substitutions: OMSEP examination forms may **not** be substituted for other examination forms. If another examination is anticipated/required, (i.e. FLIGHT, RELAD) at the same time as the OMSEP examination the appropriate forms for each particular examination should be provided to the examiner so they may be completed at the same time. Duplicate laboratory tests are not required, so long as all specific tests and procedures required for each exam are completed and reported.
  - (5) Exposure data records: Any available exposure data, from workplace surveys, industrial hygiene personal or area monitoring, material safety data sheets, or assigned IH/SEHO other appropriate sources, will be provided by OMSEP coordinator to the examining medical officer as part of the examination packet. These data should be supplied by the local unit, in coordination with the supporting industrial hygienist, prior to the examination. The protocols in Section 12-C, in addition to OSHA regulations, specify what exposure surveillance data must be maintained and made available to the examining medical officer.
- b. Tracking Report: Individual units, in coordination with the cognizant SEHO, are responsible for creating and managing a roster of all OMSEP enrollees and providing the designated medical officer advisor (DMOA)/clinic and MLC(k)'s with an updated report. Once fully implemented medical officers will be able to access this information through the OMSEP database. Updates to the tracking report will be possible by placing the information directly into the database. This will preclude the need for any additional written reports. The report should include all information cited in Section 12-A-3(a)(3) and will form the basis for the OMSEP database.
  - c. Sentinel Occupational Health Event Reporting: The occurrence of a new illness or disease, which is likely associated with an occupational exposure or condition, may be considered a "sentinel event." Such an event may serve as a warning signal that the quality of preventive measures may need to be improved. In order to facilitate timely intervention, the initial diagnosis of any such diseases must be reported IAW Section 7-B of this Manual. A complete list of reportable occupational diseases is found in Figure 7-B-2.
4. Medical Removal Protection. It is the responsibility of the commanding officer to assure a safe and healthy working environment. The finding of a work-related illness or injury, which could be further exacerbated by continued exposure to a workplace hazard or condition, requires immediate evaluation to determine whether the worker must be at least temporarily removed from further exposure. A recommendation to remove the member should be made by the examining medical officer and cognizant SEHO, in coordination with the unit's Commanding Officer. (See section 12-B-4-b).



5. Roles and Responsibilities. The OMSEP is part of a larger and more comprehensive surveillance process requiring the coordinated effort of various district units and local commands working to secure the safety and health of Coast Guard workers. Key personnel have been identified as essential in maintaining a sound occupational health prevention program. Following is a description of their expected roles and responsibilities in this process: NOTE: For the purposes of this Chapter all references to employees, workers, personnel will be assumed to be part of the ONE DOT/CG TEAM concept. Rules, regulations, and directives apply equally to ALL unless otherwise specified.
- a. Units/Commands: Each unit must appoint an OMSEP coordinator, usually the Safety Coordinator (SC) or the Safety and Occupational Health Coordinator (SOHC), or Independent Duty Corpsman. Even if units are under one servicing clinic, the unit is still required to appoint an OMSEP coordinator and manage their respective database. The OMSEP coordinator is responsible for updating the roster of OMSEP enrollees and maintaining the unit's OMSEP personnel tracking report, ensuring OMSEP examinations are completed in a timely fashion, and ensuring all available exposure data is available to the medical officer at the time of the OMSEP examination.
  - b. MLC (k): MLC (k)'s will ensure that SEHO/IH work-site monitoring and reporting is completed and entered into the appropriate database. Additionally they will provide oversight to the local units ensuring the accuracy and completeness of the OMSEP personnel tracking report. The MLC (k)'s medical officers will provide oversight over the physical examination consultation and referral process. MLC (k)'s will also provide indicated guidance and or training to HS personnel on examination practices and procedures.
  - c. SEHOs: SEHOs will be required to review all requested OMSEP enrollments from the unit OMSEP Coordinators. SEHOs will approve or disapprove requested enrollments through the on-line database. Disapprovals need to be explained to the requesting unit. To substantiate enrollments, SEHOs will be required to conduct and update quantitative and/or qualitative IH assessments of their units' workplace environment. SEHOs will be required to have these written assessments available to the medical officer for review, if requested, to determine the appropriate medical surveillance protocol to use. SEHOs will also be required to provide training and day-to-day consultation with their unit OMSEP Coordinators on database management.
  - d. Commandant (G-WKS): Commandant (G-WKS) will provide planning, development, and expertise on occupational health issues. G-WKS is responsible for policy making, procedural decisions, and ensuring currency of Chapter 12 of the Medical Manual with OSHA standards. The G-WKS occupational medicine medical officer will provide support on physical examination problems and review all diagnosed occupational health related abnormalities encountered by the on-site provider. A yearly report, updating the status of the member's abnormalities, will be provided to onsite providers. G-WKS is the final authority on decisions of any OMSEP related problems.
  - e. Medical Officer's Responsibilities:
    - (1) Medical Diagnosis coding. The examining medical officer is responsible for explaining and/or following any abnormalities through to a resolution. All diagnoses made must be appropriately coded using ICD-9CM diagnostic coding,



or most current version. ICD codes should be noted in parentheses next to the diagnosis on the examination report and be reported to the fifth digit.

- (2) Written assessment or opinion. Whenever a physical exam is performed, the examining medical officer must include the following information **in writing** as part of the record of each examination. This information should be included in the appropriate blocks.
  - (a) The occupationally pertinent results of the medical examination.
  - (b) An opinion about adequacy of the information available to support any diagnosed occupational disease(s), if appropriate.
  - (c) Any recommended limitations to the employee's assigned work.
  - (d) A statement that the employee has been informed about the results of the examination.
  - (e) Any additional written information required by the protocols listed in Section 12-C.

f. Medical Administrators:

- (1) Support. Medical Administrators are responsible for providing administrative assistance on all OMSEP related matters. This support should extend to :
  - (a) All units within the designated AOR.
  - (b) Contracted medical providers and their respective facilities.
  - (c) IDT's.
- (2) OMSEP report/worksite data. Medical Administrators should interact with OMSEP coordinators within their AOR to ensure currency of the roster of enrollees and ensure that work-site information is received in a timely matter. Worksite exposure information, reported history of past exposures and safety data sheets should precede the physical examination to give the medical officer ample time to reach an educated decision.
- (3) Physical Examinations/Medical Records. The Medical Administrator is responsible for the following clinic functions in support of OMSEP:
  - (a) Timely scheduling of physicals.
  - (b) Providing qualified technicians to perform the indicated laboratory and radiological procedures.
  - (c) Ensuring proper calibration of equipment, and
  - (d) Compliance with quality assurance standards.

- g. Civilian Employees: Civilian OMSEP enrollees may be entitled to services provided by Coast Guard medical facilities should a determination be made by a medical provider,



that an adverse health condition resulted from a work place exposure. Employees are expected to report and explain any illnesses or injuries resulting from exposure sources outside their primary duty station or from other non-occupational settings. Should a determination of an injury or illness, resulting from an exposure at the workplace, be made by a medical provider, civilian appropriated fund employees should contact their servicing civilian Command Staff Advisor (CSA) for assistance in making a claim with the Department of Labor. Non-appropriated fund employees (NAF) should contact their immediate supervisor and/or personnel liaison office. The services provided by the Coast Guard facilities will be only to establish an occupationally-related illness/injury. Further medical care should be provided by the civilian employee's health care provider.

- h. Others: In the event of an emergency situation with heavy exposure (e.g., fire, spill), 24-hour assistance is available from the Agency for Toxic Substances Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-639-0615/6360



Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-639-0615-6360.

### LIST OF ABBREVIATIONS

|               |   |
|---------------|---|
| ACGIH         | American Conference of Governmental Industrial Hygienists   |
| ALT           | Alanine aminotransferase  |
| AST           | Aspartate amino transferase   |
| BUN           | Blood urea nitrogen   |
| CBC           | Complete blood count  |
| CNS           | Central nervous system  |
| CXR           | Chest x-ray   |
| DOT           | Department of Transportation  |
| EL            | Excursion limit (OSHA mandated maximal “safe” airborne concentration of a substance)                      |
| FVC           | Forced vital capacity   |
| FEV-1         | Forced expiratory volume at one second  |
| ICD-9         | International Classification of Diseases, 9 <sup>th</sup> Revision (coding system for medical diagnoses.) |
| IH            | Industrial hygiene or industrial hygienist  |
| LDH           | Lactic dehydrogenase  |
| MCV           | Mean corpuscular volume   |
| MCH           | Mean corpuscular hemoglobin   |
| MCHC          | Mean corpuscular hemoglobin concentration   |
| MLC (k)/(kse) | Maintenance and Logistics Command: (k)-medical; ((kse)-safety & environmental health.                     |
| MO            | Medical officer (physician, physician’s assistant or nurse practitioner )                                 |
| MSAL          | Medical surveillance action level (Defined in 12-A-3)   |
| OMSEP         | Occupational Medical Surveillance and Evaluation Program  |
| OSHA          | Occupational Safety and Health Administration   |
| PEL           | Permissible exposure limit (The OSHA mandated TWA airborne exposure limit)                                |
| PFTs          | Pulmonary function tests  |



LIST OF ABBREVIATIONS (continued)

|        |  |
|--------|--|
| RBC    | red blood cell   |
| SC     | Safety Coordinator   |
| SEHO   | Safety and Environmental Health Officer  |
| SOHC   | Safety and Occupational Health Coordinator   |
| STEL   | Short-term exposure limit (The maximal “safe” airborne concentration of a substance)     |
| STEL/C | Short-term exposure limit/ceiling (maximal “safe” airborne concentration of a substance) |
| STS    | Significant threshold shift  |
| TB     | Tuberculosis   |
| TLV    | Threshold limit value (ACGIH) (The TWA airborne concentration of a substance)            |
| TST    | tuberculin skin test (Mantoux)   |
| TWA    | time-weighted average  |
| U/A    | Urinalysis   |



## Section B - Administrative Procedures.

1. General. All medical examinations and procedures required under the OMSEP shall be performed by or under the supervision of a licensed medical officer and an accredited laboratory shall perform all laboratory tests. Timely completion and monitoring of scheduled examinations is essential in identifying work related health hazards and any specific health effects. All tests required as part of an OMSEP examination should be completed prior to and the results made available to the health care provider at the time of the physical examination. This requirement may be waived if travel or time costs make separate visits impractical. **The provider is required to review, approve (sign), and explain any abnormalities. Any unexplained, examination finding, laboratory abnormality, or test result must be referred to a certified Occupational Health Clinic/provider for further evaluation.**
2. Examination Types.
  - a. Initial/baseline. Baseline examinations are required before placement in a specific job in order to assess whether the worker will be able to do the job safely, to meet any established physical standards, and to obtain baseline measurements for future comparison. Each baseline examination shall consist of all of the elements specified under the appropriate surveillance protocol(s) in Section 12-C. Table 12-B-1 also summarizes the required forms and tests for a baseline examination under each of the surveillance protocols. In the event that the employee is being monitored under more than one protocol, each unique form or test need only be completed once for a particular examination.
    - (1) An initial examination is required for all employees prior to employment. The employee may not be exposed to a potential health hazard until the physical examination is completed. In the event of scheduling delays, this requirement may be waived, if the employee completes ALL the necessary laboratory tests specified under the appropriate surveillance protocol(s). The physical examination must still be completed at the earliest possible date, but not beyond 30 days after the initial date of employment. Longer delays will require temporary removal. Workers who transfer from operational to administrative positions on a frequent basis during the same duty assignment may, with medical officer approval, receive a periodic physical vice a complete baseline examination upon re-entering the hazardous work site.
    - (2) All employees must have a physical examination prior to reassignment to any position with an occupational health hazard exposure as defined in Section 12-A-2-b. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.
    - (3) Any employee actively monitored in the OMSEP, identified, as at risk of exposure to a new health hazard requiring additional protocols, should have an initial examination performed for the new potential exposure(s). The employee may not be placed at risk of exposure until the examination is completed. During such an examination, both the initial examination requirements for the additional protocol and the periodic examination requirements for the original protocol(s) should be met. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.



b. Periodic.

- (1) Once enrolled in the OMSEP, periodic examinations will be performed at the required interval for the duration of the health hazard exposure. Periodic examinations are generally provided at twelve-month intervals, though under some exposure protocols, the period between exams may vary. Each periodic examination shall consist of all of the elements specified under the appropriate surveillance protocol(s). See Section 12-C. and Table 12-B-1. If an employee is being monitored under more than one protocol, each form or test need only be completed once during a particular examination.
- (2) Periodic laboratory monitoring may be required under certain protocols (e.g., lead, pesticides) or special situations. These examinations consist of the specified **laboratory tests only**, and are usually performed in accordance with the specific protocol or as often as deemed necessary by the medical provider.

c. Acute Exposure.

- (1) An acute health hazard exposure examination is required, under some protocols, (e.g., benzene, hazardous waste, noise, solvents), when the applicable short-term exposure limit (STEL) ceiling limit of the substance(s) in question is exceeded. The requirement applies whether or not the employee exhibits any overt symptoms of acute exposure. Specific requirements, if any, for an acute exposure examination are found under the protocols in Section 12-C.
- (2) An acute health hazard exposure examination is recommended if the employee exhibits any adverse effects following an acute exposure to a suspected hazardous substance. If the substance(s) is identified, an examination should be performed following the specific protocol(s) for that substance(s). In the event no specific substance is identified, an examination should be directed according to the “Unspecified” examination protocol and presenting symptoms. The Acute Chemical Exposure Information form (Figure 12-B-1) should be used to collect and organize information when an acute exposure occurs. The information on this form must accompany the employee to his/her examination.
- (3) All HAZMAT response personnel with a documented exposure event, including Coast Guard Strike Team members and firefighters, must complete an Acute Chemical Exposure Information form (Figure 12-B-1) at the end of each HAZMAT response. Special attention must be provided to the type, duration and degree of toxicity of the agent(s) encountered as well as the type of contact (inhalation, skin absorption, ingestion). The type of PPE utilized, type of respirator (if any), and protective clothing worn should also be noted. This information is to be entered in the member’s medical record.

- d. Exit/Separation (Employment/Exposure). Exit exams are designed to assess pertinent aspects of the worker’s health when the worker leaves employment or when exposure to a specific hazard has ceased. Results may be beneficial in assessing the relationship of any future medical problem to an exposure in the workplace. Exit physical examinations must be completed within 30 days of the last day of exposure or employment. The worker may not be re-assigned to a hazardous area once the examination is completed. In the event the worker is exposed to a hazardous substance, after completing the examination, ALL laboratory tests required by the specific protocol for that particular



substance must be repeated (see Table 12-B-1 and Section 12-C). The following conditions also apply:

(1) End of Exposure:

- (a) OMSEP enrollees assigned to a non-hazardous work environment but likely to be assigned to a designated area later in their career.
- (b) Workers who transfer from operational to administrative positions on a frequent basis may, with medical officer approval, receive an update to their periodic physical vice a complete exit (end of exposure) examination. This does not preclude a complete exit/separation examination upon the end of employment.
- (c) Individuals enrolled in the OMSEP, with exposures to known carcinogens or agents with prolonged latency periods for disease development (e.g., asbestos, benzene), will receive an end of exposure exam upon reassignment to non-hazardous area and continue to receive updates to their periodic physicals according to the designated protocol(s). These individuals will be monitored for the duration of their Coast Guard career unless the responsible supervising medical officer or other cognizant medical authority determines such monitoring is not required.

(2) End of Employment:

- (a) OMSEP enrollees permanently separating from Coast Guard employment should receive an end of employment examination.
- (b) The member's permanent home of record and phone number must be secured for notification of any abnormalities.
- (c) A copy of the member's occupational health history, including all potential exposure agents, severity and duration of exposure, and any recommendations on future protocol testing or examinations, must be placed in the member's medical record. A personal copy should also be provided to the member. (see Section 12-B-3-j).

- e. Timing of next examination. The default interval between examinations is one year for all protocols except respirator wear and prior (not current) exposure to asbestos, in which case the default interval is **five years**. However, exams may be recommended as infrequently as biennially for employees monitored solely under the protocols for chromium compounds, hazardous waste, solvents, and unspecified exposures. **A medical officer may recommend for any individual patient a shorter interval between examinations than the default period, if such is medically indicated.** Any recommendation on the timing of the next examination should be included as part of the physician's written assessment.

3. Use of OMSEP Forms.

- a. CG Form 5447 (6-00) (History and Report of OMSEP Examination).



- (1) This form must be completed whenever an OMSEP physical examination is required, except when only annual hearing conservation program is needed. Ensure that the examinee and medical officer identifying information are accurately recorded, including phone numbers.
  - (2) For an initial examination, all history sections on the CG-5447 must be completed. For subsequent examinations, as an alternative to completing all the blocks in history Sections I through IV, the examinee may choose to initial the statement above each section noting that there have been no changes during the interval from the last examination.
  - (3) The CG-5447 (6-00) replaces the SF 88 and SF 93 continuation forms and incorporates CG-5197 and the existing CG-5447 (3-97). Previous editions are obsolete.
- b. OSHA Respirator Medical Evaluation Questionnaire-(mandatory). This questionnaire is to be completed by any worker who is to be issued a respirator or assigned to a task that may require a respirator.
  - c. CG-5140 (Audiometric Biological Calibration Check). This form is to be used to record calibration of the audiometric equipment.
  - d. CG-5552 (Audiology History Questionnaire). This form provides a chronological record of audiologic symptoms and recreational noise exposure. It should be initiated at the time of enrollment in the hearing conservation program and OMSEP surveillance for occupational noise exposure. This form must be updated at each subsequent annual audiogram and reviewed by the responsible medical officer.
  - e. DD Form 2215 (Reference Audiogram). This form is used to record initial audiometric test results.
  - f. DD Form 2216 (Hearing Conservation Data). This form is used to record the results of periodic and follow-up audiometry for individuals routinely exposed to hazardous noise. This form should be preceded by a reference audiogram (DD Form 2215 or other record) already on file in the individual's health record.
  - g. Notification of Summary Results. A sample of this form is provided in Figure 12-B-2. A photocopy or a locally generated form may be used to provide the required notification to the enrollee of the results of his/her OMSEP examination.
  - h. Acute Chemical Exposure Information Form. This form is used to record the results of any unexpected exposures and for verification of notification of the appropriate agencies. A sample of this form is provided in Figure 12-B-1.
  - i. Separation Letter. This letter serves as notification of the member's documented exposure(s) while serving in the US Coast Guard. It provides the nature and levels of exposure(s), if known, and the medical provider's comments and recommendations. A copy is to be placed in the member's record and another provided directly to the member. A sample of the separation letter is provided as Figure 12-B-4.



- j. Patient Notification. The medical officer is responsible for notifying the patient of any and all abnormalities found or diagnoses made, whether or not they are occupationally related or simply an incidental finding. Notification must be made within 30 days of completion of the examination and should be documented as a medical record entry (see Figure 12-B-2).
4. Medical Removal Standards.
- a. The following abnormal laboratory findings during an OMSEP examination mandate immediate removal of the employee from further workplace exposure to the hazard listed, pending resolution of the abnormality or a determination that the abnormality is not due to a workplace exposure. The medical officer should coordinate all medical removal recommendations with the cognizant SEHO before forwarding to the commanding officer (CO).
    - (1) Benzene (**any** of the following):
      - (a) The hemoglobin/hematocrit falls below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.
      - (b) The thrombocyte (platelet) count varies more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.
      - (c) The leukocyte count is below 4,000 per mm<sup>3</sup> or there is an abnormal differential count.
    - (2) Lead: A blood lead level at or above 40µg/100 ml of whole blood.
    - (3) Noise: A loss of hearing of  $\geq 35$  dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz), compared with the **current** reference audiogram.
    - (4) Organophosphate pesticides: cholinesterase level at or below 50% of the pre-exposure baseline.
  - b. Pregnancy is not a reason for automatic medical removal from the workplace. A decision to remove or restrict a pregnant woman must be based on sound clinical judgment after careful consideration of the workplace environment and the woman's physical capabilities. The woman's pre-natal health care provider (obstetrician) should be apprised early of any/all potential hazards and safety precautions available.
5. Reporting of Examination Results.
- a. Coast Guard medical officers will have 30 days from completion of the examination to meet all medical officer responsibilities in Section 12-B-4.



- b. Contractual providers, IDTs, and other detached HSs/units must forward all OMSEP examination questions, problems, and any unresolved matters, with accompanying supporting information, to the assigned CG medical officer for review within 15 days of receipt (includes the examination and any additional testing or consultations).
- c. All records must be forwarded to the record custodian upon compliance with Sections 12-B-6- (a) and 12-B-6 (b) above.



TABLE 12-B-1

## REQUIRED FORMS AND TESTS FOR VARIOUS OMSEP EXAMINATIONS AND PROTOCOLS

| Exam Type<br>Exposure<br>Protocol | Initial/<br>Baseline   | Periodic  | Exit/Separation   | Acute<br>Exposure  | Biological<br>Monitoring  |
|-----------------------------------|--|---|---|--|---|
| Asbestos                          | CG 5447<br><b>*OSHA<br/>Resp.<br/>Quest.</b><br>SF88&93<br><br>Stool<br>guaiac (a)*<br>PFTs<br>“B” reader<br>CXR<br>CBC<br>Multichem<br>panel<br>U/A w/<br>micro | CG 5447<br>(update)<br><br>Stool guaiac<br>(a)*<br>PFTs<br>“B” reader<br>CXR(b)*<br>CBC<br>Multichem<br>panel<br>U/A w/ micro | CG 5447 (update)<br><br>Stool guaiac (a)*<br>PFTs<br>“B” reader CXR<br>CBC<br>Multichem panel<br>U/A w/ micro | N/A  | N/A   |
| Benzene                           | CG 5447<br>SF88&93<br>CBC w/<br>diff<br>Multichem<br>panel<br>U/A w/<br>micro  | CG 5447<br>(update)<br><br>CBC w/ diff<br>Multichem<br>panel<br>U/A w/ micro  | CG 5447 (update)<br><br>CBC w/diff<br>Multichem panel<br>U/A w/ micro   | CG 5447<br>(update)<br>Urinary<br>phenol<br>CBC w/<br>diff<br><b>Acute<br/>Exposure<br/>Form</b> | Only under<br>special<br>circumstan<br>ces.<br>Contact G-<br>WKS-3. |
| Chromates                         | CG 5447<br>SF88&93<br><br>CXR<br>PFTs<br>CBC<br>Multichem<br>panel<br>U/A w/<br>micro  | CG 5447<br>(update)<br><br>PFTs<br>CBC<br>Multichem<br>panel<br>U/A w/ micro  | CG 5447 (update)<br><br>CXR<br>PFTs<br>CBC<br>Multichem panel<br>U/A w/ micro                                 | N/A  | N/A   |

\* OSHA Medical Evaluation Respiratory Questionnaire. Note: DD Forms 2493-1/2493-2 Asbestos Report may be required at medical DOD facilities.



TABLE 12-B-1 (Continued)

| Exam Type<br>Exposure<br>Protocol | Initial/<br>Baseline  | Periodic  | Exit/Separation   | Acute<br>Exposure   | Biological<br>Monitoring  |
|-----------------------------------|---|---|---|---|---|
| Hazardous<br>Waste                | CG 5447<br>SF88&93<br>vision<br>screening<br>CXR<br>PFTs<br>CBC w/<br>diff<br>Multichem<br>panel<br>U/A w/<br>micro | CG 5447<br>(update)<br><br>vision<br>screening<br>PFTs<br>CBC w/ diff<br>Multichem<br>panel<br>U/A w/ micro | CG 5447 (update)<br><br>vision screening<br>CXR<br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447<br>(update)<br><b>Acute<br/>Exposure<br/>Form</b><br><br>PFTs<br>CBC w/<br>diff<br>Multichem<br>panel<br>U/A w/<br>micro<br>Heavy<br>metal<br>screen (c)* | Only under<br>special<br>circumstan<br>ces.<br>Contact G-<br>WKS-3. |

NOTES: \*(a) only if patient is age 35+ or otherwise clinically indicated.

\*(b) B-reader chest x-rays will be done at periodic examinations according to the following schedule:

| <u>Years since<br/>first exposure</u> | <u>Age of examinee</u> |                 |                |
|---------------------------------------|------------------------|-----------------|----------------|
|                                       | <u>15 to 35</u>        | <u>36 to 45</u> | <u>over 45</u> |
| 0 to 10                               | Every 5 yrs.           | Every 5 yrs.    | Every 5 yrs.   |
| Over 10                               | Every 5 yrs.           | Every 2 yrs.    | Annually       |

\*(c) Heavy metal screen includes blood lead, cadmium, mercury, and arsenic levels.



TABLE 12-B-1 (Continued)

| Exam Type<br>Exposure<br>Protocol | Initial/<br>Baseline  | Periodic   | Exit/Separation  | Acute<br>Exposure   | Biological<br>Monitoring         |
|-----------------------------------|---|--|--|---|----------------------------------|
| Lead                              | CG 5447<br>SF88&93<br><br>Blood lead<br>& ZPP<br>CBC w/<br>diff<br>Multichem<br>panel<br>U/A w/<br>micro                        | CG 5447<br>(update)<br><br>Blood lead &<br>ZPP<br>CBC w/ diff<br>Multichem<br>panel<br>U/A w/ micro                    | CG 5447 (update)<br><br>Blood lead & ZPP<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro                       | CG 5447<br>(update)<br><b>Acute<br/>Exposure<br/>Form</b><br><br>Blood lead<br>& ZPP<br>CBC w/<br>diff<br>Multichem<br>panel<br>U/A w/<br>micro | Blood lead,<br>ZPP               |
| Noise                             | CG-5552<br><br>DD Form<br>2215 *  | CG-5552<br>(update)<br>DD Form<br>2216 *   | CG-5552 (update)<br><br>DD Form 2216 *   | CG-5447<br>(update)<br>DD Form<br>2216 *  | N/A                              |
| Pesticides                        | CG 5447<br>SF88&93<br>Blood<br>cholin-<br>esterase,<br>twice<br>PFTs<br>CBC w/<br>diff<br>Multichem<br>panel<br>U/A w/<br>micro | CG 5447<br>(update)<br><br>Blood cholin-<br>esterase (d)*<br>PFTs<br>CBC w/ diff<br>Multichem<br>panel<br>U/A w/ micro | CG 5447 (update)<br><br>Blood cholin-<br>esterase (d)*<br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447<br>(update)<br><b>Acute<br/>Exposure<br/>Form</b><br><br>Blood<br>cholin-<br>esterase<br>(d)*<br>PFTs                                   | Blood<br>cholinester<br>ase (c)* |

Note: DD Forms 2215/2216 remain active and are to be properly recorded and maintained in the member's medical record. DOD facilities continue to use these forms or an electronic equivalent.

CG facilities may continue to use these forms; an equivalent locally reproduced form or electronic version as long as they comply with regulations set forth in Chapter 4 of this Manual.

NOTES: \*(d) Blood cholinesterase only required if exposure includes organophosphate and/or carbamate pesticides.



TABLE 12-B-1 (Continued)

| Exam Type<br>Exposure<br>Protocol | Initial/<br>Baseline   | Periodic   | Exit/Separation  | Acute<br>Exposure   | Biological<br>Monitoring  |
|-----------------------------------|--|--|--|---|---|
| Respiratory<br>Sensitizers        | CG 5447<br>SF 88&93<br><br>PFTs<br>CBC w/<br>diff<br>Multichem<br>panel<br>U/A w/<br>micro | CG 5447<br>(update)<br><br>PFTs<br>CBC w/ diff<br>Multichem<br>panel<br>U/A w/ micro                                       | CG 5447 (update)<br><br>PFTs<br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro | CG 5447<br>(update)<br><b>Acute<br/>Exposure<br/>Form</b><br><br>PFTs   | N/A   |
| Solvents                          | CG 5447<br>SF 88&93<br><br>CBC w/<br>diff<br>Multichem<br>panel<br>U/A w/<br>micro         | CG 5447<br>(update)<br><br>CBC w/ diff<br>Multichem<br>panel<br>U/A w/ micro<br>Biological<br>moni-toring<br>(if possible) | CG 5447 (update)<br><br>CBC w/ diff<br>Multichem panel<br>U/A w/ micro         | CG 5447<br>(update)<br><b>Acute<br/>Exposure<br/>Form</b><br><br>Specific<br>blood or<br>urine tests<br>for specific<br>solvents. | Specific<br>blood or<br>urine tests<br>for specific<br>solvents.<br>(See<br>Section 12-<br>C-11.d.) |
| Respirator<br>wear only           | CG 5447<br>** OSHA<br>Resp Quest   | **ORQ<br>(update)  | N/A  | N/A   | N/A   |

\* Respiratory: OSHA Respiratory Questionnaire, this form is provided at the unit level (worksites),  
(Reference Section 12-c-9.



TABLE 12-B-1 (Continued)

| Exam Type<br>Exposure<br>Protocol | Initial/<br>Baseline  | Periodic   | Exit/Separation  | Acute<br>Exposure   | Biological<br>Monitorin<br>g  |
|-----------------------------------|---|--|--|---|---|
| Tuberculosis                      | CG 5447<br>Sf 88&93<br><br>Mantoux<br>skin test<br>(e)*                 | Mantoux skin<br>test (e)*  | Mantoux skin test<br>(e)*                                      | Mantoux<br>skin test<br>(e)*  | N/A   |
| Unspecified                       | CG 5447<br>SF 88&93<br><br>CBC<br>Multichem<br>panel<br>U/A w/<br>micro | CG 5447<br>(update)<br><br>CBC<br>Multichem<br>panel<br>U/A w/ micro | CG 5447 (update)<br><br>CBC<br>Multichem panel<br>U/A w/ micro | CG 5447<br>(update)<br><b>Acute<br/>Exposure<br/>Form</b><br><br>CBC<br>Multichem<br>panel<br>U/A w/<br>micro | Only<br>under<br>special<br>circumsta<br>nces.<br>Contact<br>G-WKS-<br>3. |

NOTES:       \*(e) Personnel with a history of reactive tuberculin skin tests should be monitored for development of symptoms of active TB. A CXR should be done **only** if the skin test is newly reactive.



FIGURE 12-B-1

**ACUTE CHEMICAL EXPOSURE INFORMATION**

| <u>Last Name, First Name, M.I.</u>  | <u>Rank/Rate</u>   | <u>SSN</u>   |
|---|--|--|
| 1. Name(s) of chemical(s): _____  | _____  | _____  |
| 2. CAS number(s), if known: _____   | _____  | _____  |
| 3. Physical form:   | <input type="checkbox"/> Solid <input type="checkbox"/> Liquid<br><input type="checkbox"/> Gas/Vapor<br><input type="checkbox"/> Aerosol | <input type="checkbox"/> Solid <input type="checkbox"/> Liquid<br><input type="checkbox"/> Gas/Vapor<br><input type="checkbox"/> Aerosol |
| 4. Chemical form:   | <input type="checkbox"/> Acid <input type="checkbox"/> Alkali<br><input type="checkbox"/> Organic solvent                                | <input type="checkbox"/> Acid <input type="checkbox"/> Alkali<br><input type="checkbox"/> Organic solvent                                |
| 5. Modes or routes of exposure:   | <input type="checkbox"/> Inhalation<br><input type="checkbox"/> Ingestion <input type="checkbox"/> Skin                                  | <input type="checkbox"/> Inhalation<br><input type="checkbox"/> Ingestion <input type="checkbox"/> Skin                                  |
| 6. Exposure date, time & duration:  | Date/time _____<br>Duration _____ minutes  | Date/time _____<br>Duration _____ minutes  |
| 7. Brief description of the incident:   |  |  |
| 8. Observed symptoms:   |  |  |
| 9. Associated injuries:   |  |  |
| 10. Personal Protective Equipment Used:   |  |  |
| <b>Notify District/ISC Safety &amp; Environmental Health Officer, cognizant MLC (kse), and G-WKH-3.</b> |  |  |
| 11 Further guidance received:   |  |  |
| <b>Contact ATSDR emergency response line at 404-649-0615 to obtain further guidance.</b>                |  |  |
| 12. ATSDR guidance:   | <u>Prescribed tests:</u>   | <u>Time limits for specimens</u>   |
|   |  | <u>Other</u>   |

Attach Material Safety Data Sheet (MSDS) and shipping manifest to this form, if available.

*(Use reverse for continuation or reporting of additional information.)*







## HISTORY AND REPORT OF OMSEP EXAMINATION

Page 1



FIGURE 12-B-3 (cont'd)

| <b>Section III. Social History (continued)</b>   |          |   |          |          |                                 |                      |   |                                 |          |          |                                   |
|--|----------|---|----------|----------|---------------------------------|----------------------|---|---------------------------------|----------|----------|-----------------------------------|
| <b>28. Other smoking history:</b>  |          |   |          |          | <b>29. Alcohol use history:</b> |                      |   |                                 |          |          |                                   |
| <b>Y</b>   | <b>N</b> |   |          |          | <b>Y</b>                        | <b>N</b>             |   |                                 |          |          |                                   |
|  |          | Do you smoke cigars or a pipe now?            |          |          |                                 |                      | Do you drink any alcoholic beverages (beer, wine, liquor)?      |                                 |          |          |                                   |
|  |          | If NO: Did you ever smoke cigars or a pipe?   |          |          |                                 |                      | If YES: How many bottles/cans of beer per week?                 |                                 |          |          |                                   |
|  |          | If you smoked before, what year did you stop? |          |          |                                 |                      | How many glasses of wine per week?                              |                                 |          |          |                                   |
|  |          | How many years had you smoked?                |          |          |                                 |                      | How many ounces of liquor per week?                             |                                 |          |          |                                   |
|  |          | How many cigars or pouches per week?          |          |          |                                 |                      | 30. Do you use any other recreational drugs? If so, list below. |                                 |          |          |                                   |
|  |          | If YES: How many years have you smoked?       |          |          |                                 |                      |   |                                 |          |          |                                   |
|  |          | How many cigars or pouches per week?          |          |          |                                 |                      |   |                                 |          |          |                                   |
| <b>IV. Personal Health History (patient must complete)</b><br><br>_____ Initial here if the answers to the following questions are all "NO" and there have been no changes since your last exam, then go to item 32.<br>31. Have you <i>recently</i> had or do you <i>now have</i> any of the following symptoms or complaints, yes or no? |          |   |          |          |                                 |                      |   |                                 |          |          |                                   |
| <b>Y</b>   | <b>N</b> |   | <b>Y</b> | <b>N</b> |                                 | <b>Y</b>             | <b>N</b>  |                                 | <b>Y</b> | <b>N</b> |                                   |
|  |          | Unexplained weight loss                       |          |          | Difficulty sleeping             |                      |   | Chest pain or angina            |          |          | Birth defects in your children    |
|  |          | Fever or chills                               |          |          | Red or irritated eyes           |                      |   | Palpitations or irregular heart |          |          | Pain or blood with urination      |
|  |          | Skin rashes or ulcers                         |          |          | Visual disturbances or changes  |                      |   | Other heart trouble             |          |          | Muscle pain or weakness           |
|  |          | Lumps you can feel                            |          |          | Sinus trouble (pain, discharge) |                      |   | Abdominal pain                  |          |          | Joint pain or swelling            |
|  |          | Severe or recurrent headaches                 |          |          | Nosebleeds                      |                      |   | Gastritis or peptic ulcers      |          |          | Limitations of motion             |
|  |          | Dizziness or vertigo                          |          |          | Sore throat, trouble swallowing |                      |   | Jaundice or yellowing skin      |          |          | Back pain                         |
|  |          | Fainting or passing out                       |          |          | Pain or swelling in neck        |                      |   | Nausea or vomiting              |          |          | Numbness, tingling in extremities |
|  |          | Seizures or epilepsy                          |          |          | Frequent coughing               |                      |   | Constipation                    |          |          | Anemia ("low blood")              |
|  |          | Trouble concentrating                         |          |          | Coughing phlegm or blood        |                      |   | Diarrhea or runny stools        |          |          | Easy bruising or bleeding         |
|  |          | Mood changes, irritability                    |          |          | Wheezing or asthma              |                      |   | Bloody or tarry stools          |          |          | HIV/AIDS                          |
|  |          | Tiredness or fatigue                          |          |          | Shortness of breath             |                      |   | Infertility or miscarriages     |          |          | Cancer or leukemia                |
| 32. In general, would you say your health is (check one): Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>  |          |   |          |          |                                 |                      |   |                                 |          |          |                                   |
| 33. List any medications you are currently using, or state "none".<br><br><div style="text-align: center; font-size: 2em; color: blue; opacity: 0.5; transform: rotate(-45deg); pointer-events: none;">SAMPLE FORM</div>   |          |   |          |          |                                 |                      |   |                                 |          |          |                                   |
| 34. List any allergies you know you have, or state "none".<br><br>   |          |   |          |          |                                 |                      |   |                                 |          |          |                                   |
| 35. Additional space for comments and explanations of your "yes" answers:<br><br>  |          |   |          |          |                                 |                      |   |                                 |          |          |                                   |
| All information provided will be handled in accordance with Privacy Act requirements, and will not be otherwise disclosed.   |          |   |          |          |                                 |                      |   |                                 |          |          |                                   |
| I hereby certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.   |          |   |          |          |                                 | Signature of patient |   |                                 |          | Date     |                                   |



FIGURE 12-B-3 (cont'd)

## Occupational Exposure History

[illegible]



## MEDICAL OFFICER'S SECTION

|  |  |   |                                     |
|--|--|---|-------------------------------------|
| 1. Last Name, First Name, M.I. ( <i>of patient</i> )   | 2. Grade/Rate/Rank ( <i>of patient</i> )                           | 3. SSN ( <i>of patient</i> )  | 4. Date of Examination              |
| 5. Examining facility or examiner name and address:  |  |   | 6. Facility phone number<br>(     ) |
| 7. Surveillance protocols followed ( <i>check all that apply</i> )<br><br><input type="checkbox"/> Asbestos <input type="checkbox"/> Chromium compounds <input type="checkbox"/> Lead <input type="checkbox"/> Pesticides <input type="checkbox"/> Respiratory sensitizers <input type="checkbox"/> Unspecified<br><br><input type="checkbox"/> Benzene <input type="checkbox"/> Hazardous waste <input type="checkbox"/> Noise <input type="checkbox"/> Respiator wear <input type="checkbox"/> Solvents <input type="checkbox"/> Other:_____                               |  |   |                                     |
| 8. Medical Officer Initial Here: _____ Verify completion of SF-93 & SF-88. Initial Baseline _____  |  |   |                                     |
| 9. General prevention counseling provided to patient 9check any that were addressed with patient)<br><br><input type="checkbox"/> Tobacco cessation <input type="checkbox"/> Physical activity <input type="checkbox"/> Weight reduction <input type="checkbox"/> HIV/STD's avoidance <input type="checkbox"/> Injury prevention<br><br><input type="checkbox"/> Alcohol or drug abuse <input type="checkbox"/> Nutrition (low-fat/salt) <input type="checkbox"/> Stress reduction <input type="checkbox"/> Breast/testicular self exam <input type="checkbox"/> Other:_____ |  |   |                                     |
| 10. List current diagnoses by ICD-9 code number and name: ( <i>If no exactly corresponding ICD-9 code is available, use the closest code to the named diagnosis.</i> )   |  |   |                                     |
| ICD-9  | Diagnosis  | ICD-9   | Diagnosis                           |
|  |  |   |                                     |
|  |  |   |                                     |
|  |  |   |                                     |
|  |  |   |                                     |
| 11. In your opinion, was the information to you adequate to support any listed diagnoses of occupational disease? <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |                                     |
| 12. Respirator wear  | This examinee <input type="checkbox"/><br><input type="checkbox"/> | Is medically approved for respirator wear. ( <i>Comment on any restrictions or limitations</i> )<br>Is not            |                                     |
| 13. CONCLUSIONS:   | This examinee <input type="checkbox"/><br><input type="checkbox"/> | Has medical conditions which limit his/her performance of duties. ( <i>Specify any limitations</i> )<br>Does not have |                                     |
| 14. Next OMSEP examination should be in <input type="checkbox"/> 12 mos. <input type="checkbox"/> Other_____   |  |   |                                     |
| 15. Examinee was informed about the results of this examination_____(date).  |  |   |                                     |
| SAMPLE FORM  |  |   |                                     |
| Printed or typed name (rank) and degree of examining medical officer   |  | Signature of examining medical officer  | Date                                |



FIGURE 12-B-4

**OMSEP**

**SEPARATION LETTER**

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_  
DATE: \_\_\_\_\_

You have been enrolled in the Coast Guard's OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP). During the past \_\_\_\_\_ years you received periodic physical examinations based on Occupational Health Safety Organization (OSHA) protocols for the following known potentially hazardous exposures:

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Your occupational (work-related) history also indicates suspected exposure to the following agents:

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At the time of your EXIT/SEPARATION medical examination you were found to be in good health with no evidence occupational induced disease. However, it is recommended that you continue to receive medical examinations on a periodic basis based on age indicated guidelines. In addition, the periodicity of the examination should be modified to allow for adequate detection and prompt intervention on disease processes resulting from the latent effects of occupational hazardous substances. Your medical provider should follow OSHA mandated recommendations, for the aforementioned hazardous substances, in determining the frequency and level of care you require. NOTE: if a member is found to have an occupational related disease process at the time of separation, indicated medical referral measures will be instituted.

Any questions relating to this member's occupational health history can be obtained by contacting the US Coast Guard's Office of Safety and Environmental Health at # 202-267-1883.

Medical officer signature

- This letter should printed on official Coast Guard Letterhead for inclusion in members official health record.



## Section C - Medical Examination Protocols.

### 1. General.

- a. The following protocols follow the same format. Each contains a brief description of the hazard and its possible effects; the conditions required for an individual to be surveyed under that protocol; information which must be provided to the examining medical officer; specific requirements of the history and physical, including laboratory tests and special procedures; and any additional written requirements on the part of the examining medical officer. The protocols are summarized in Figures 12-C-1 through 12-C-12. Copies of these figures may be locally reproduced. The unit OMSEP coordinator should complete the information in the first eight blocks at the very top, and the appropriate protocol summary figure(s) should be provided to the examining medical officer with the examination packet.
- b. Multiple protocols for a single individual. In the event that an individual is being monitored on more than one protocol (e.g., asbestos and noise), the final examination packet must include each of the required items for each of the protocols. However, each required form or test need only be completed once.
- c. Past exposure. Personnel who have a documented history of workplace exposure to known carcinogens, but who are not currently exposed, shall be offered an annual medical examination, according to this protocol until end of employment. Undergoing this examination is strictly voluntary.

### 2. Asbestos (Figure 12-C-1).

- a. Exposure effects. Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent. There is a synergistic effect between asbestos exposure and cigarette smoking, so that the risk of lung cancer is roughly ten times greater in asbestos-exposed workers who smoke as opposed to nonsmoking asbestos-exposed workers. The primary route of exposure is inhalation, though ingestion of fibers may also occur.
- b. Required surveillance.
  - (1) All personnel with current employment exposure to airborne asbestos, who meet the MSAL criteria in Section 12-C-2- (4) below, shall undergo medical surveillance. These personnel shall be included in the OMSEP and be examined according to the protocol in Section 12-C-2.d below. Medical examinations shall be provided upon enrollment and at least annually thereafter, throughout the duration of exposure or until end of employment, whichever comes first. Under current Coast Guard policies for management of asbestos, very few non-shipyard workers should be currently exposed at or above the PEL or EL.
  - (2) Construction worker standard. The OSHA standard for asbestos applies to, but is not limited to, workers who demolish, remove, alter, repair, maintain, install, clean up, transport, dispose of, or store asbestos containing materials.
  - (3) The current MSALs are based on the OSHA exposure standard for shipyards [29 CFR 1915.1001].



- (a) For other than shipyard and construction workers, medical surveillance is required for those employees who are or will be exposed at or above the PEL as an 8 hour time-weighted average, or above the EL averaged over 30 minutes, regardless of the number of days of exposure.
  - (b) For shipyard and construction workers, medical surveillance is required for those workers:
    - 1 Who remove any asbestos-containing materials, or who perform repair and maintenance operations in which asbestos-containing materials are likely to be disturbed, is such work is performed for a combined total of 30 or more days per year, regardless of fiber levels;
    - 2 Who are exposed at or above the PEL or EL for a combined total of 30 or more days per year; or
    - 3 Who are required to wear positive pressure respirators while performing asbestos-related work, regardless of the number of days respirators are worn.
- c. Information to medical officer. The following information must be provided to the examining medical officer, by the OMSEP coordinator, prior to the examination taking place:
  - (1) A copy of the OSHA asbestos standards [29 CFR 1915.1001], with appendices D and E.
  - (2) A description of the affected employee's duties as they relate to the employee's exposure.
  - (3) The employee's representative exposure level or anticipated exposure level.
  - (4) A description of any personal protective or respiratory equipment used or to be used.
- d. Examination protocol.
  - (1) Each initial, periodic, and exit examination shall include, as a minimum:
    - (a) A medical and work history. Emphasis should be placed on the member's history of tobacco use (smoking), and associated symptoms of dyspnea on exertion, recurrent epigastric discomfort, pleuritic chest pains or unexplained cough.
    - (b) Completion of the OSHA Respiratory Medical Evaluation Questionnaire Appendix C to RP Standard 29CFR 1910.134. Note: additional information on asbestos reporting guidelines may be found at [www.osha.gov](http://www.osha.gov).
    - (c) A complete physical examination of all systems, with emphasis on the respiratory system, the cardiovascular system, and digestive tract.
    - (d) A stool guaiac test, if the patient is age 35 or over.



- (e) PFTs, including FVC and FEV1.
- (f) Routine screening labs, including a CBC, multichemistry panel (including glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and U/A with microscopic.
- (g) A postero-anterior (PA) CXR, in accordance with the schedule and interpretation requirements in Section 12-C-2-d(2) below;
- (h) Any other tests or procedures deemed appropriate by the examining physician, including specialty consultations.

(2) Chest x-ray requirements:

- (a) A PA CXR shall be performed at the initial examination and then according to the following schedule:

| <u>Years since</u><br><u>First exposure</u> | <u>Age of examinee</u> |                 |                |
|---|------------------------|-----------------|----------------|
|   | <u>15 to 35</u>        | <u>36 to 45</u> | <u>over 45</u> |
| 0 to <u>10</u>                              | Every 5 yrs.           | Every 5 yrs.    | Every 5 yrs.   |
| Over 10                                     | Every 5 yrs.           | Every 2 yrs.    | Annually       |

- (b) A PA chest-x-ray shall be performed at the exit examination.
- (c) All CXRs shall be interpreted and classified in accordance with a professionally accepted classification system and recorded following the format of the CDC/NIOSH (M) 2.8 form. A B-reader or a board eligible/certified radiologist using the ILO-U/C International Classification of Radiographs for Pneumoconiosis references shall only do the interpretation.
- (d) Assistance in obtaining the location of the nearest B-reader is available from MLC (k).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the examining physician must address the following in writing:

- (1) Any detected medical conditions placing the employee at increased risk of health impairment from further asbestos exposure.
- (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.
- (3) Employee notification of the results of the examination and any medical conditions resulting from asbestos exposure that might require follow-up.
- (4) Employee notification of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

3. Benzene (Figure 12-C-2).

- a. Exposure effects. Benzene exposure can cause central nervous system depression, leukemia, aplastic anemia, and dermatitis. The primary route of exposure is inhalation



of vapors, though skin absorption may also occur. Within the Coast Guard, most benzene exposure occurs among marine inspectors and oil spill responders.

b. Required surveillance.

- (1) The Coast Guard MSALs are based on the OSHA action level and PEL standards. Enrollment in the OMSEP is required for all personnel:
  - (a) who are or may be exposed to benzene at or above the current average exposure action level 30 or more days per year,
  - (b) who are or may be exposed to benzene at or above the current short-term exposure action level 10 or more days per year, or
  - (c) who served as resident inspectors, pollution investigators, marine safety officers, port safety officers, vessel inspectors, or marine investigators prior to 1990. These personnel are considered to have been exposed at/or above the MSAL unless otherwise documented.
- (2) In addition to routine surveillance requirements above, if an employee is exposed to benzene in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs. after the exposure, and an acute exposure examination will be performed within 72 hrs. of the exposure. Such an examination must contain a urinary phenol test on the collected urine specimen.

c. Information to medical officer. The following information must be provided to the examining physician, by the OMSEP coordinator, prior to the examination taking place:

- (1) A description of the affected employee's duties as they relate to the employee's exposure.
- (2) The employee's representative exposure level or anticipated exposure level.
- (3) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocols.

- (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
  - (a) A detailed history which includes:
    - 1 past occupational exposure to benzene or any other hematological toxins, at work or at home;
    - 2 a family history of blood dyscrasias, including hematological neoplasms;
    - 3 a personal history of blood dyscrasias, including genetic hemoglobin abnormalities, bleeding abnormalities, abnormal function of formed blood elements; and of renal or liver dysfunction;



- 4 history of exposure to ionizing radiation;
    - 5 smoking history, alcohol usage history, and all medicinal drugs routinely taken;
    - 6 any current history of headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, or weight loss.
  - (b) a complete physical examination, (Ensure the patient is examined for mental status changes, dermatitis, and pallor.);
  - (c) a CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC);
  - (d) a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;
  - (e) any other tests or procedures deemed appropriate by the examining physician.
- (2) Each acute exposure examination shall include, as a minimum:
  - (a) a brief summary of the nature of the exposure and investigation of any symptoms or complaints;
  - (b) a total urinary phenol level (mg/L) or a urinary phenol adjusted for urinary creatinine (mg/g creatinine), plus a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC).
  - (c) If either the total urinary phenol level is below 50 mg phenol/L of urine, or the urinary phenol adjusted for urinary creatinine is less than 250 mg/g creatinine, and the CBC is normal, no further testing is required. Otherwise, contact Commandant (G-WKS-3) for further requirements.
- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the following must be addressed in writing by the examining medical officer:
  - (1) Any detected medical conditions, which would place the employee's health at greater than normal risk of material impairment from exposure to benzene.
  - (2) The medical officer's recommended limitations upon the employee's exposure to benzene or upon the employee's use of protective clothing or equipment and respirators.
  - (3) A statement that the employee has been informed by the medical officer of the results of the examination and any medical conditions resulting from benzene exposure which require further explanation or treatment.
- 4. Chromium Compounds (Figure 12-C-3) .



- a. Exposure effects. Hexavalent chromium compounds are known human carcinogens. They may also cause dermatitis, skin ulceration, occupational asthma, and nasal septum perforation. The primary routes of exposure are percutaneous absorption and inhalation. Chromates may be found in certain metal alloys, paints, and masonry cements. Within the Coast Guard, most chromate exposure is from the use of chromium containing paints.
- b. Required surveillance. The Coast Guard MSALs are based on the ACGIH threshold limit values (TLVs). Medical surveillance is required for all personnel who are or may be exposed to chromium IV compounds at or above the current exposure action level 30 or more days per year.
- c. Information to medical officer. The following information must be provided by the OMSEP coordinator to the examining physician prior to the examination taking place:
  - (1) A description of the affected employee's duties as they relate to the employee's exposure.
  - (2) The employee's representative exposure level or anticipated exposure level.
  - (3) A description of any personal protective or respiratory equipment used or to be used.
- d. Examination protocols. Each routine initial, annual (periodic), and exit examination must include:
  - (1) A detailed history, which includes:
    - (a) Past and current occupational exposures to chromate, asbestos, or any other pulmonary carcinogens at work or at home;
    - (b) Smoking history and alcohol usage history;
    - (c) Any past or current history of dry skin, skin ulcers—usually painless, nosebleeds, asthma, shortness of breath, wheezing, or cough;
  - (2) A directed physical examination, with attention to the skin, mucous membranes, and respiratory tract, both upper and lower (ensure the patient is examined for erosion of the nasal mucosa and septum, respiratory rhonchi, dermatitis, and cutaneous ulcers);
  - (3) A CBC, multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a U/A with microscopic;
  - (4) PFTs (including FVC & FEV<sub>1</sub>);
  - (5) A PA CXR **only** for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);
  - (6) Any other tests or procedures deemed appropriate by the examining physician.
- e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:



- (1) The periodicity of the next routine medical surveillance examination.  
Examinations will be provided annually unless the physician recommends a longer interval.
  - (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.
5. Hazardous Waste (Figure 12-C-4).
  - a. Exposure effects. The OSHA medical surveillance protocol for hazardous waste operations and emergency response (HAZWOPER)[29 CFR 1910.120] involves medical surveillance for potential exposure to numerous metals and chemicals, usually in uncontrolled—spill, fire, disposal—situations. Therefore, there are no specific exposure effects to describe.
  - b. Required surveillance.
    - (1) Routine medical surveillance is required for employees involved in hazardous waste operations when any of the following conditions are met:
      - (a) Exposure or potential exposure to hazardous substances or health hazards at or above the MSAL for that substance (as defined in Section 12-A-4), without regard to the use of respirators or personal protective equipment, for 30 or more days per year.
      - (b) All hazardous waste operation employees who wear a respirator for 30 or more days per year or as required under Section 12-C-9.
      - (c) All employees who are injured, become ill, or develop signs or symptoms due to possible overexposure involving hazardous substances or health hazards from an emergency response or hazardous waste operation.
      - (d) Members of HAZMAT response teams, including all Coast Guard Strike Team members and firefighters.
    - (2) In addition to routine surveillance requirements above, if an employee is exposed to a hazardous substance above the Coast Guard MSAL in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs. after the exposure, and an acute exposure examination will be performed within 72 hrs. of the exposure.
  - c. Information to medical officer. The examining medical officer shall be provided, by the OMSEP coordinator, one copy of the OSHA HAZWOPER standard [29 CFR 1910.120] and its appendices, plus the following specific information:
    - (1) A description of the employee's duties as they relate to the employee's exposures.
    - (2) The employee's exposure levels or anticipated exposure levels.
    - (3) A description of any personal protective equipment used or to be used, including any respirators.
    - (4) Information from previous medical examinations of the employee which is not readily available to the examining physician.



d. Examination protocols.

- (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
  - (a) A medical and occupational history which includes:
    - 1 past and current occupational exposure to hazardous chemicals, metals, dusts, fumes, and heat stress;
    - 2 any history of heat illness, allergies, sensitivities, or physical abnormalities;
    - 3 current medications, and immunization history;
    - 4 smoking history, and alcohol usage history;
    - 5 a complete review of organ systems.
  - (b) A complete physical examination with attention to the skin, eyes, nose, throat, and respiratory, cardiovascular, genitourinary, and neurologic systems;
  - (c) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC);
  - (d) A multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;
  - (e) PFTs (including FVC & FEV1);
  - (f) Vision screening;
  - (g) A PA CXR only for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);
  - (h) Any other tests or procedures deemed appropriate by the examining physician. (Consider a stool guaiac and/or electrocardiogram, if indicated by age or physical findings).
- (2) Each acute exposure examination shall include, as a minimum:
  - (a) A brief summary of the nature of the exposure and investigation of any symptoms or complaints;
  - (b) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic;
  - (c) PFTs (including FVC & FEV1);



- (d) Appropriate biological monitoring tests (e.g., blood metal screen) depending on the exposure in question. Contact Commandant (G-WKS-3) for further information and requirements.
- e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:
  - (1) Whether the employee has any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from work in hazardous waste operations or emergency response, or from respirator use.
  - (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.
  - (3) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.
- 6. Lead (Figure 12-C-5).
  - a. Exposure effects. In adults, excessive lead exposure can cause hypertension, anemia, peripheral neuropathy, encephalopathy, spontaneous abortions in women, and decreased fertility in men. The primary route of exposure in adults is inhalation of lead containing dust or fumes. Most exposure in the Coast Guard occurs during removal of previously applied lead-based paint coatings, or during environmental recovery of previously discarded lead-acid batteries. Some welders may be exposed to lead fumes.
  - b. Required surveillance. The Coast Guard MSAL is based on the OSHA PEL standard for shipyards [29 CFR 1915.1025]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to lead at or above the current exposure action level for 30 or more days per year.
  - c. Information to medical officer. The OMSEP coordinator shall provide the medical officer with one copy of the OSHA lead standard [29 CFR 1915.1025] and its appendices, plus the following specific information:
    - (1) A description of the employee's duties as they relate to the employee's exposure.
    - (2) The employee's exposure level or anticipated exposure levels to lead and to any other toxic substance (if applicable).
    - (3) A description of any personal protective equipment used or to be used, including any respirators (if known).
    - (4) Prior blood lead determinations.
    - (5) Information from previous medical examinations of the employee which is not readily available to the examining physician. This includes all available prior written medical opinions concerning the employee.
  - d. Examination protocols.
    - (1) Biological monitoring or "blood lead only" examinations must be provided to each employee exposed at or above the OSHA action level (currently TWA of 30 µg/m<sup>3</sup> air) **every six months**. Otherwise, only annual examinations must be



performed, unless an employee's blood lead level is found to be elevated at or above 40 µg/100 ml of whole blood.

- (2) Each routine initial, periodic, exit, and acute exposure examination shall include, as a minimum:
  - (a) A detailed work history and a medical history, with particular attention to:
    - 1 past lead exposure (occupational and non-occupational);
    - 2 personal habits (smoking, handwashing after work and before eating);
    - 3 past and current gastrointestinal, hematological, renal, cardiovascular, reproductive, and neurological problems.
  - (b) A complete physical examination with particular attention to:
    - 1 ocular fundi, teeth, gums, hematological, gastrointestinal, renal, cardiovascular, and neurological systems;
    - 2 blood pressure (must be recorded);
    - 3 pulmonary status should be evaluated if respiratory protection is to be used. (See Section 12-C-9).
  - (c) The following routine laboratory tests:
    - 1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology;
    - 2 blood lead level and zinc protoporphyrin (must be performed by a laboratory licensed by the CDC for proficiency in blood lead testing);
    - 3 a multi-chemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase);
    - 4 a U/A with microscopic examination; and,
    - 5 PFTs (including FVC & FEV 1).
  - (d) Any other tests or procedures deemed appropriate by the examining physician (pregnancy testing, laboratory examination of male fertility).
- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:
  - (1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure from lead, or from respirator use.
  - (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.



(3) The results of the blood lead determinations.

7. Noise (Figure 12-C-6)

- a. Exposure effects. The primary effect of excessive noise is to cause loss of hearing. This hearing loss may be described by three “p-words:” painless, progressive, and permanent. Cumulative overexposures to hazardous noise levels cause millions of people to lose hearing during their working lives.
- b. Required surveillance. The Coast Guard MSAL is based on DOD Instruction 6055.12, DOD Hearing Conservation Program, as well as OSHA guidance [29 CFR 1910.95]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to hazardous noise at or above the current exposure action level for 30 or more days per year. However, personnel who infrequently or incidentally enter designated “hazardous noise areas” need not participate in the audiometric testing program.

(1) Enrollment is required in accordance with the following criteria:

- (a) When the member is exposed to continuous and intermittent noise that has an 8-hour time-weighted average (TWA) noise level of >85 decibels A-weighted (dBA), or is exposed to impulse noise sound pressure levels (SPLs) of 140 decibels (dB) peak, or greater.
- (b) When a threshold shift of > 35 dB is noted in the speech frequencies.

(2) Reference (baseline) audiograms:

- (a) All personnel shall receive a reference audiogram prior to any Coast Guard occupational noise exposure or before they are assigned to duties in “hazardous noise areas”.
- (b) Every effort should be made to schedule the reference audiogram on civilian workers in order to avoid conflicts with assigned duties; military personnel shall receive their reference audiogram at initial entry training.
- (c) Testing to establish a reference audiogram shall be preceded by at least 14 hours without exposure to workplace noise. Hearing protectors that attenuate workplace noise below a TWA of 85 dBA, may be used to meet this requirement, in place of exclusion from the noisy workplace.

(3) Exit audiograms: shall be conducted on all employees, previously enrolled in the “hearing conservation program”, if it is determined the employee no longer works in a designated “hazardous noise area,” unless that employee is moving to another Coast Guard position that also involves work in such areas. However, if the employee’s audiogram shows hearing losses (compared to the reference audiogram) of greater than 35 dB in the speech frequencies (500 - 3000 Hz) the employee must continue to receive annual audiograms until end of employment.

- c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with a description of the employee’s duties as they relate to the employee’s exposure, the dB level of the hazardous work area and a description of any personal protective equipment used or to be used (e.g., earplugs or earmuffs).



d. Examination protocols.

- (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include completion or updating of an Audiology History Questionnaire (CG 5552) and audiometric testing (audiogram). All audiometric testing shall:
  - (a) Be performed by a licensed or certified audiologist, otolaryngologist, or other physician; or by a technician who is certified by the Council for Accreditation in Occupational Hearing Conservation or who has completed CG HS “A” school. A technician who performs audiometric tests shall be responsible to an audiologist, otolaryngologist, or other physician. Standard instructions shall be given to individuals before testing.
  - (b) Be conducted in a testing environment with background octave band SPLs not greater than 27 dB at 500 Hz, 29 dB at 1000 Hz, 34 dB at 200 Hz, 39 dB at 4000 Hz, and 41 dB at 8000 Hz. The test environment shall be surveyed annually to ensure these levels are not exceeded.
  - (c) Include pure tone, air conduction, and hearing threshold examinations of each ear at the test frequencies of 500, 1000, 2000, 3000, 4000, and 6000 Hz.
  - (d) Be performed on audiometers conforming to the most current calibration specifications of the American National Standards Institute (ANSI). Audiometers currently in operation must receive annual electroacoustic calibration to maintain certification.
  - (e) Occur on audiometers that have received a functional operations check before each day’s use for specifications in the OSHA Occupational Noise Exposure standard [29 CFR 1910.95]
  - (f) Be recorded on DD Form 2215 (Reference Audiogram), or DD Form 2216 (Hearing Conservation Data), or equivalent locally reproduced versions as appropriate.
- (2) Significant Threshold Shift (STS). Transcribe the reference audiogram test results into the “Reference Audiogram” spaces on the DD Form 2216, Hearing Conservation Data. The reference levels are subtracted from the current levels at 2000, 3000, and 4000 Hz. The differences in hearing levels calculated at 2000, 3000, and 4000 Hz are added together and divided by three, for each ear. STS exists if the resulting average hearing loss in either ear is greater than or equal to  $\pm 10$  dB [29 CFR 1910.95]. Additionally, any change of  $\pm 15$  dB at 1000, 2000, 3000, or 4000 Hz in either ear shall constitute an STS. Results shall be recorded on DD Form 2216. Aging (presbycusis) can contribute to the change in hearing level. When determining whether an STS has occurred, note the following: The TRACOR microprocessor audiometer automatically corrects for aging. The National Institute for Occupational Safety and Health (NIOSH) age corrections shall **not** be applied when determining STS if a microprocessor audiometer is used for the test.



- (3) A follow-up audiogram shall be conducted when an individual's audiogram shows an STS, in either ear, relative to the current reference audiogram. Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. An audiologist, otolaryngologist, or other knowledgeable physician shall perform the evaluation and determine if the noise-induced STS is/is not work-related or has/has not been aggravated by occupational noise exposure.
- (4) When a negative STS (improvement in hearing threshold from the reference audiogram) is noted on the periodic audiogram, one 14-hour noise-free follow-up test is required. That may be administered on the same day as the periodic test. The results of the follow-up test may be used to create a re-established reference audiogram.
- (5) When a positive STS (decrease in hearing threshold from the reference audiogram) is noted on the periodic audiogram, two consecutive 14-hour noise-free follow-up tests must be administered to confirm if the decrease in hearing is permanent. The follow-up exams may not be performed on the same day as the periodic audiogram. The results of the second follow-up test may be used to reestablish a reference audiogram. If the results of the first follow-up test do not indicate an STS, a second follow-up test is not required.
- (6) A new reference audiogram shall replace the original reference audiogram when the medical evaluation confirms that the STS noted during the annual and follow-up audiograms is permanent. The original reference audiogram shall be retained in the patient's medical record.
- (7) Acute exposure examinations (formerly called the Detailed Surveillance Program). These examinations are designed to observe any dynamic hearing loss, to identify those who demonstrate unusual noise sensitivity, or to monitor personnel acutely exposed to unprotected high levels of noise (impulse >140dba).
  - (a) The initial acute exposure examination shall consist of all elements described in Sections 12-C-7.d. (1)-(6), above. Additional follow-up audiograms will be performed at 30 and 90 days, or at more frequent intervals at the discretion of the medical officer.
  - (b) If any of the follow-up audiograms demonstrate an average loss of no more than 10 dB in 2000, 3000, and 4000 Hz in either ear, when compared to the revised reference audiogram, hearing may be considered stable. The reference audiogram (per Section 12-C-7-d (5) and (6)) remains the audiogram against which further testing is compared. The individual is returned to annual monitoring.
  - (c) If these reevaluation audiograms exhibit a loss greater than an average threshold of 10 dB in 2000, 3000, and 4000 Hz in either ear when compared to the revised reference audiogram, the individual must be referred to an otolaryngologist for a consultation. Final disposition will depend on the consultant's diagnosis and recommendations.



- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the medical officer must do the following:
- (1) The employee shall be notified in writing within 21 days, when an audiologist or a physician confirms a positive threshold shift is permanent. Such determination must be entered in the employee's medical record.
  - (2) Supervisors shall be notified, in writing, that the worker has experienced a decrease in hearing. Release of medical information must conform to privacy act requirements.
  - (3) Document that the patient was counseled concerning the potential seriousness of repeated unprotected exposures to excessive noise and provided additional information on hearing protection and avoidance of hazardous noise exposures.

8. Pesticides (Figure 12-C-7)

- a. Exposure effects. There are over 1,200 chemical compounds currently classified as pesticides. However, this surveillance protocol is primarily concerned with only two classes of pesticides: organophosphate and carbamate insecticides, and chlorophenoxyacetic acid herbicides. Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase and they cause parasympathetic nervous system hyperactivity (miosis, urination, diarrhea, defecation, lacrimation, salivation), neuromuscular paralysis, CNS dysfunction (irritability, anxiety, impaired cognition, seizures, coma), peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy. In the past, some chlorophenoxyacetic herbicides were contaminated with dioxins during manufacture.
- b. Required surveillance. The Coast Guard MSALs for carbaryl, chlorpyrifos, malathion, parathion, 2,4, -D, and 2,4,5,-T are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified pesticide at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year.
- c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:
- (1) A description of the employee's duties as they relate to the employee's exposure.
  - (2) The employee's exposure level or potential exposure level to any pesticides.
  - (3) A description of any personal protective equipment used or to be used, including any respirators.
- d. Examination protocols.
- (1) Biological monitoring or "RBC cholinesterase only" examinations must be provided at least **every six months** to each employee exposed to organophosphate or carbamate pesticides at or above the MSAL. If an employee's RBC cholinesterase activity is found on any testing to be less than 80% of the pre-exposure baseline, the frequency of biological monitoring will be increased to at least **every three months during the application season**. Non-seasonal, acute



exposures will be monitored at a frequency determined by the supervising medical officer based on exposure information data.

- (2) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
  - (a) A detailed work history and a medical history, with particular attention to:
    - 1 past and current exposure to pesticides or other chemicals (occupational and non-occupational);
    - 2 smoking and alcohol use history;
    - 3 any symptoms of eye, nose, or throat irritation; cough; nausea, vomiting, diarrhea, or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; and
    - 4 allergic skin conditions or dermatitis.
  - (b) A complete physical examination, with attention to the skin, respiratory, and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).
  - (c) The following routine laboratory tests:
    - 1 A CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;
    - 2 An erythrocyte (RBC) cholinesterase level.
    - 3 **Initial examination only—two RBC cholinesterase tests must be drawn at least 24 hrs. apart.** The results of these two tests will be averaged to provide the pre-exposure baseline for future reference, unless they differ by more than 15% from each other, in which case, additional testing must be performed until successive tests do not differ by more than 15%. The pre-exposure baseline blood tests must be drawn after a period of at least 60 days without known exposure to organophosphates.
  - (d) Any other tests or procedures deemed appropriate by the examining physician (e.g., cognitive function testing). Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.
- (3) Each acute exposure examination shall include, as a minimum:
  - (a) A medical and work history with emphasis on any evidence of eye, nose, or throat irritation; cough; nausea, vomiting, diarrhea, or abdominal pain;



irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities.

- (b) A complete physical examination with attention to any reported symptoms as well as the skin, respiratory, and nervous systems. A mental status examination must be performed.
  - (c) An erythrocyte (RBC) cholinesterase level.
  - (d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, cognitive function testing, urinary metabolites—if less than 24 hrs. post acute exposure). Pulmonary function testing should be performed at least every 4 years if the employee wears a respirator.
- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:
- (1) Any detected medical conditions, which would place the employee's health at increased risk from exposure to identified pesticides or from respiratory wear.
  - (2) Counseling on the possible increased risk of health impairment from working with certain pesticides, in the event that the employee was found to have skin disease, chronic lung disease, or abnormalities of the central or peripheral nervous system that could directly or indirectly be aggravated by such exposure.

9. Respirator Wear (Figure 12-C-8)

- a. Exposure effects. The OSHA medical surveillance protocol for respirator wear is a means to assess the effectiveness of respiratory protection among exposed workers. Periodic examinations are required to assess continued fitness for duties and to assess whether the present respiratory protection program provides adequate protection against illness. Respirators are often extremely uncomfortable to wear for long periods. Workers with asthma, claustrophobia, angina, and other conditions may not be able to wear respirators effectively. The worker should be questioned for a history or symptoms of past and current exposures to hazardous chemicals; fumes and dusts; smoking and alcohol use histories; wheezing or abnormal breath sounds; clubbing; and cardiac arrhythmia.
- b. Required surveillance.
  - (1) Initial Medical Determination. An initial/baseline examination will be performed at the time of assignment to a job requiring respirator wear. Before an employee may be issued a respirator or assigned to a task that may require a respirator, that worker must complete a mandatory OSHA Respirator Medical Evaluation Questionnaire. This questionnaire will be provided, at the local unit by the cognizant SEHO, to all workers expected to require the use of a respirator. This questionnaire serves as the initial medical examination. A health care professional (nurse, nurse practitioner, physician assistant, and physician) must review this questionnaire to determine if a follow-up medical examination is required. Independent duty technicians (IDT'S) are authorized to review the questionnaire but must refer any positive responses on questionnaire (or any other concerns) to



the supervising medical officer for further review. Any employee who gives a positive response to any questions among questions 1-8 in section two of the questionnaire shall be subject to a follow-up medical examination. This examination will determine whether the worker is physically and mentally capable of performing the work and using a respirator [29 CFR 1910.134].

(2) Additional Medical Evaluation and Medical Examination.

(a) Additional medical examinations are required to assess continued fitness for duties involving respirator wear. The following conditions will trigger the need for a follow-up evaluation:

- 1 The member reports signs and symptoms related to the ability to use a respirator;
- 2 The health care provider, supervisor, or respirator program coordinator informs the command of the need for re-evaluation;
- 3 Observations are made during fit testing, respirator use, or program evaluation that indicate the need for re-evaluation;
- 4 When changes in workplace conditions such as physical work effort, protective clothing or climate conditions result in substantial increase in physiological burden;
- 5 At the same time of the member's schedule quintennial physical examination.

(b) Periodic physical examinations will be provided at least once every five years. The periodic physical examination requires a review and update of the respirator questionnaire. A health care provider must review the questionnaire to determine the need for a follow-up examination. A follow-up medical examination is required for anyone with positive responses to questions 1-8 in section two of the questionnaire.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

- (1) A description of the employee's duties as they relate to the employee's respirator wear.
- (2) The employee's exposures or potential exposures to any hazardous chemicals or physical agents.
- (3) A description of the respirator(s) used or to be used.

d. Examination protocol. Each routine (non-acute exposure) initial and periodic examination shall include, as a minimum:

- (1) A medical and work history, including:
  - (a) history of exposure to hazardous chemicals, fumes, and dusts;



- (b) smoking and alcohol use history;
  - (c) any history of claustrophobia, asthma, angina, other respiratory or cardiovascular disease.
- (2) A system specific physical examination, with attention to the pulmonary and cardiovascular systems.
- (3) Any other tests or procedures deemed appropriate by the examining physician.
- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:
  - (1) Any detected medical conditions that would place the employee at increased risk of material impairment of the employee's health from respirator use.
  - (2) Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree ( $FEV_1$  or  $FVC < 70\%$  of predicted) should not be routinely approved to wear a respirator. Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).

#### 10. Respiratory Sensitizers (Figure 12-C-9)

- a. Exposure effects. Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).
- b. Required surveillance. The Coast Guard MSALs for formaldehyde, toluene diisocyanate, and vanadium, are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified respiratory sensitizer at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year. In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.
- c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:
  - (1) A description of the employee's duties as they relate to the employee's exposure.
  - (2) The employee's exposure level or anticipated exposure level to any respiratory sensitizers.
  - (3) A description of any personal protective equipment used or to be used, including any respirators.
- d. Examination protocols.



- (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
  - (a) A detailed work history and a medical history, with particular attention to:
    - 1 past and current exposure to respiratory sensitizers (occupational and non-occupational);
    - 2 smoking history;
    - 3 any symptoms of eye, nose, or throat irritation;
    - 4 chronic airway problems or hyperactive airway disease; and
    - 5 allergic skin conditions or dermatitis.
  - (b) In the event that the employee is not required to wear a respirator and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a system specific physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).
  - (c) The following routine laboratory tests:
    - 1 a CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;
    - 2 PFTs (including FVC & FEV<sub>1</sub>).
  - (d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CXR, bronchial provocation tests).
- (2) Each acute exposure examination shall include, as a minimum:
  - (a) A medical and work history with emphasis on any evidence of upper or lower respiratory problems, allergic conditions, skin reaction or hypersensitivity, and any evidence of eye, nose, or throat irritation.
  - (b) A directed physical examination with attention to the respiratory system.
  - (c) PFTs (including FVC & FEV<sub>1</sub>).
  - (d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, bronchial provocation tests).
- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:



- (1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure to identified respiratory sensitizers, or from respirator use.
- (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

#### 11. Solvents (Figure 12-C-10)

- a. Exposure effects. There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when considered as an admittedly broad group. These effects are skin disorders (acute irritant dermatitis, chronic eczema), acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma), and chronic CNS effects (chronic solvent intoxication, neurobehavioral abnormalities, cognitive dysfunction). Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic to humans; benzene being a notable exception (see Section 12-C-3, above). In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).
- b. Required surveillance. The Coast Guard MSALs for ethylene glycol, methyl ethyl ketone, VM & P naphtha, and xylene are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified hazardous solvent at or above the MSAL (as defined in Section 12-A-2) for 30 or more days per year. An acute exposure examination is required in the event of any documented overexposure (above the TLV or STEL) to a solvent or any presumed overexposure where symptoms are present. In the case of an acute overexposure, an appropriate urine or blood specimen should be collected as soon as possible after the overexposure incident.
- c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:
  - (1) A description of the employee's duties as they relate to the employee's exposure.
  - (2) The employee's exposure level or potential exposure level to any solvents.
  - (3) A description of any personal protective equipment used or to be used, including any respirators.
- d. Examination protocols.
  - (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
    - (a) A detailed work history and a medical history, with particular attention to:
      - 1 past and current exposure to solvents (occupational and non-occupational);
      - 2 smoking history and alcohol use history;



- 3 any symptoms of dry skin, skin irritation, or dermatitis;
      - 4 any CNS symptoms, including headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, difficulty concentrating, mood changes, or confusion;
      - 5 a review of symptoms with attention to the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems.
    - (b) A system specific physical examination, with attention to the skin and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).
    - (c) The following routine laboratory tests:
      - 1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC); and
      - 2 a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic.
    - (d) Consideration should be given to biological monitoring tests for ongoing overexposure to certain solvents, if specimens can be obtained in a timely manner during the exposure period. For non-acute exposures, a timely manner generally implies that the specimen be obtained at the end of a work shift or the end of a workweek.
      - 1 For toluene, measure urinary hippuric acid, at the end of a full work shift.
      - 2 For xylene, measure urinary methyl-hippuric acid, at the end of a full work shift.
      - 3 For methylethylketone (MEK), measure urinary MEK, at the end of a full work shift.
      - 4 For trichloroethylene, measure urinary trichloroacetic acid, at the end of a full workweek.
    - (e) Any other tests or procedures deemed appropriate by the examining physician (e.g., cognitive function tests. Note that skin (patch) testing is generally of little value in solvent-induced dermatitis, since the pathophysiology is generally not allergic. Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.
  - (2) Each acute exposure examination shall include, as a minimum:



- (a) A medical and work history with emphasis on any evidence of skin disorders or acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma).
  - (b) A system specific physical examination with attention to the skin and nervous systems.
  - (c) If at all possible, a biological monitoring test for overexposure to the solvent in question should be performed, if such a test is available and a specimen can be obtained in a timely manner. For acute exposures, a timely manner implies within the first half-life of the chemical within the human body, generally a matter of a few hours after the overexposure.
  - (d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, and bronchial provocation tests).
- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:
- (1) Any detected medical conditions, which would place the employee at increased risk of material impairment of the employee's health from any identified exposures to solvents, or from respirator use.
  - (2) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

12. Tuberculosis (Figure 12-C-11)

- a. Exposure effects. Tuberculous droplet nuclei are coughed, spoken, or sneezed into the air by an individual with active pulmonary tuberculosis. Exposure to these airborne droplet nuclei may cause infection with the bacterium that causes tuberculosis.
- b. Required surveillance. Employees who are occupationally exposed to active TB cases will be enrolled in the OMSEP and undergo annual screening for tuberculosis. See section 7-D-3 of this Manual, Tuberculosis Screening Program, for complete details. In the Coast Guard, medical personnel and personnel involved in alien migrant interdiction operations (AMIO) are at potential risk for exposure to active TB cases.
- c. Information to medical personnel. In order to assess whether the employee should remain under active surveillance for TB exposure, the OMSEP coordinator must provide the examining medical officer with the following information:
  - (1) A description of the employee's duties as they relate to the employee's exposure.
  - (2) The employee's exposure level or potential exposure level active TB cases.
  - (3) A description of any personal protective equipment used or to be used.
- d. Examination protocols.
  - (1) Routine screening for exposed individuals is covered in section 7-D-3.



- (a) Personnel with a history of non-reactive tuberculin skin tests will receive annual skin testing. Routine skin testing does not require an examination by a medical officer.
- (b) Personnel with a history of reactive skin test(s) will be monitored for development of symptoms of active TB (cough, hemoptysis, fatigue, weight loss, night sweats) annually. A health services technician or a medical officer may complete such monitoring. Routine annual CXRs will not be done.
- (2) Evaluation of personnel with newly reactive tuberculin skin tests or suspected active TB is covered in section 7-D-4. A medical officer shall perform a physical examination and obtain a complete medical history in such personnel. A CXR should be done.
- e. Specific written requirements. Requirements for recording routine skin test results are covered in Section 7-D-3-c. In addition, medical personnel should make a written recommendation as to whether continued annual TB surveillance is required.

13. Unspecified (Figure 12-C-12)

- a. Exposure effects. Individuals undergoing surveillance in this category have exposures to hazards, which are not included in any of the other protocols. Exposure effects will vary with the nature of the exposure, so there are no specific effects to describe.
- b. Required surveillance. Enrollment in the OMSEP is required whenever an employee is exposed to an identified hazard, at or above the MSAL, for 30 or more days per year.
- c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:
  - (1) A description of the employee's duties as they relate to the employee's exposure.
  - (2) The employee's exposure level or anticipated exposure level to any hazardous chemicals or physical agents.
  - (3) A description of any personal protective equipment used or to be used.
- d. Examination protocols. Each routine initial, periodic, and exit examination shall include, as a minimum:
  - (1) A medical and work history. Ensure the patient is questioned about past exposure to chemical and physical hazards, smoking history and alcohol use, a complete review of systems.
  - (2) A complete physical examination of all systems, with attention to any organ systems with a significant history or current symptoms. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).
  - (3) A CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A.
  - (4) Any other tests or procedures deemed appropriate by the examining physician. Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.



- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:
- (1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from any identified exposures to identified hazards, or from respirator use.
  - (2) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.



FIGURE 12-C-1

|   |       |        |             |
|---|-------|--------|-------------|
| Date:   | Unit: | OPFAC: | Unit POC:   |
| Patient name:   |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Other ____ |       |        |             |
| Acute Exposure <input type="checkbox"/>   |       |        |             |

## Examination Protocol for Exposure to **ASBESTOS**

| IF EXAM TYPE IS                              | ✓                                 | DO or COMPLETE THESE ITEMS  |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
|--|-----------------------------------|---|-------------------|-----------------------------------|--|--|--|------------------|------------------|-------------------|------|---------------|---------------|---------------|---------|---------------|---------------|------------|
| Initial/Baseline                             | <div><div></div><div></div></div> | CG-5447 History and Report of OMSEP Examination /<br><b>SF 88 &amp; 93</b>  |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
|  | <div><div></div><div></div></div> | DD Form 2493-1 or OSHA Respiratory Disease Questionnaire (Part 1) (optional)  |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
| Periodic/Separation or <b>Acute Exposure</b> | <div><div></div><div></div></div> | DD Form 2493-2 or OSHA Respiratory Disease Questionnaire (Part 2) ( <b>optional</b> )   |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
|  | <div><div></div><div></div></div> | <b>CG 5447</b> (update)   |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
| All types                                    | <div><div></div><div></div></div> | Complete blood count (CBC); multichemistry panel (includes liver function tests, BUN, creatinine); urinalysis with microscopic (U/A).   |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
| All types                                    | <div><div></div><div></div></div> | Pulmonary function tests (FVC & FEV <sub>1</sub> ).   |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
| Acute Exposure                               | <div><div></div><div></div></div> | <i>Acute Exposure Form</i>  |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
| All types                                    | <div><div></div><div></div></div> | Chest x-ray (PA) with “B-reader” or board certified radiologist evaluation at initial exam then per table:  |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
|  |                                   | <table><tr><td></td><td colspan="3"><i>Years since first exposure</i></td></tr><tr><td></td><td><i>Age 15-35</i></td><td><i>Age 36-45</i></td><td><i>Age &gt;45</i></td></tr><tr><td>0-10</td><td>Every 5 years</td><td>Every 5 years</td><td>Every 5 years</td></tr><tr><td>Over 10</td><td>Every 5 years</td><td>Every 2 years</td><td>Every year</td></tr></table> |                   | <i>Years since first exposure</i> |  |  |  | <i>Age 15-35</i> | <i>Age 36-45</i> | <i>Age &gt;45</i> | 0-10 | Every 5 years | Every 5 years | Every 5 years | Over 10 | Every 5 years | Every 2 years | Every year |
|  | <i>Years since first exposure</i> |   |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
|  | <i>Age 15-35</i>                  | <i>Age 36-45</i>  | <i>Age &gt;45</i> |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
| 0-10   | Every 5 years                     | Every 5 years   | Every 5 years     |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
| Over 10                                      | Every 5 years                     | Every 2 years   | Every year        |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |
| All types                                    | <div><div></div><div></div></div> | Physician’s notification regarding examination results. (Final action.)   |                   |                                   |  |  |  |                  |                  |                   |      |               |               |               |         |               |               |            |

### To the examining medical officer:

You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.

Ensure that the patient is questioned about the following history or symptoms: **smoking history, dyspnea on exertion, cough, pleuritic pain, heartburn or epigastric pain.** (See OSHA Respiratory Disease Questionnaire.)

Ensure that the patient is examined for the following possible signs: **clubbing, basilar rales.**

You must address the following four items in writing: 1) whether the employee has any detected medical conditions placing him/her at increased risk of health impairment from further asbestos exposure; 2) any recommended limitations on use of personal protective equipment; 3) that the employee has been informed by you of the results of the examination and any medical conditions resulting from asbestos exposure that require follow-up; 4) that the employee has been informed of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent.

Asbestos was used in shipbuilding until the 1970s. Exposure among OMSEP participants is mostly associated with repair and overhaul of vessels built prior to that time

If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-2

|  |       |        |             |
|--|-------|--------|-------------|
| Date:  | Unit: | OPFAC: | Unit POC:   |
| Patient name:  |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |        |             |
| Other _____  |       |        |             |

## Examination Protocol for Exposure to **BENZENE**

| IF EXAM TYPE IS                             | ✓     | DO or COMPLETE THESE ITEMS   |
|---|-------|--|
| <b>Initial/Baseline</b>                     | _____ | CG-5447 History and Report of OMSEP Examination.   |
|   | _____ | <b>SF 88 &amp; 93</b>  |
| All types                                   | _____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC).  |
| Initial/Baseline, Periodic, or Separation   | _____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, GTT, LDH, and alkaline phosphatase) |
|   | _____ | <b>U/A with microscopic</b>  |
| Periodic /Separation/ <b>Acute Exposure</b> | _____ | <b>CG 5447</b> (update)  |
| Acute exposure                              | _____ | Urinary phenol. ( <b>Only immediately after acute exposure.</b> )  |
|   | _____ | Acute Exposure Form  |
| All types                                   | _____ | Physician's notification regarding examination results. (Final action.)  |

### To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: **smoking history, headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, weight loss.**
- ◆ Ensure that the patient is examined for the following signs: **mental status changes, dermatitis, pallor.**
- ◆ Benzene exposure causes CNS depression, leukemia, aplastic anemia, and dermatitis.
- ◆ The employee should be medically removed from the workplace if any of the following are noted on the exam:
  - \* The hemoglobin/hematocrit is below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.
  - \* The thrombocyte (platelet) count has dropped more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.
  - \* The leukocyte count is below 4,000 per mm<sup>3</sup> or there is an abnormal differential count.
- ◆ Benzene is commonly associated with petrochemical manufacturing. Exposure among OMSEP participants is generally related to marine vessel inspection or disaster response (oil spill, fire). Commercial gasoline is about 3% benzene.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-3

|  |          |   |             |
|--|----------|---|-------------|
| Date:  | Unit:    | OPFAC:  | Unit POC:   |
| Patient name:  |          | SSN:  | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Other _____ |          |   |             |
| Acute Exposure <input type="checkbox"/>  |          |   |             |
| <b>Examination Protocol for Exposure to</b><br><b>CHROMATES</b>  |          |   |             |
| <b>IF EXAM TYPE IS</b>   | <b>✓</b> | <b>DO or COMPLETE THESE ITEMS</b>   |             |
| <b>Initial/Baseline</b>  | _____    | CG-5447 History and Report of OMSEP Examination/<br><b>SF 88 &amp; 93</b>   |             |
| Initial/Baseline or Separation   | _____    | Chest x-ray (PA)  |             |
| <b>Periodic/Separation/<br/>Acute Exposure</b>   | _____    | <b>CG 5447</b> (update)   |             |
| All types  | _____    | Pulmonary function tests (FVC & FEV <sub>1</sub> ).   |             |
| All types  | _____    | Complete blood count (CBC)  |             |
| All types  | _____    | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) |             |
| All types  | _____    | U/A with microscopic  |             |
| All types  | _____    | Physician's notification regarding examination results. (Final action.)   |             |

**To the examining medical officer:**

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: **smoking history, shortness of breath, wheezing, cough, dry skin, skin ulcers.**
- ◆ Ensure that the patient is examined for the following signs: **erosion of nasal mucosa and septum, respiratory rhonchi, dermatitis, cutaneous ulcers.**
- ◆ Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- ◆ Chromium exposure causes lung cancer, dermatitis, skin ulcers, and nasal septum perforation.
- ◆ Chromic acid may cause acute burns or irritation to skin, eyes, and upper respiratory tract. Inhalation may cause acute epiglottitis, laryngospasm, pneumonitis, and pulmonary edema.
- ◆ Some chromium compounds cause occupational asthma.
- ◆ Chromium compounds are commonly associated with steel and chemical manufacturing. Exposure among OMSEP participants is generally related to working with chromium containing paints.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-4

|  |       |        |             |
|--|-------|--------|-------------|
| Date:  | Unit: | OPFAC: | Unit POC:   |
| Patient name:  |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |        |             |
| Other _____  |       |        |             |

## Examination Protocol for Exposure to Hazardous Waste

| IF EXAM TYPE IS                            | ✓     | DO or COMPLETE THESE ITEMS  |
|--|-------|---|
| <b>Initial/Baseline</b>                    | _____ | CG-5447 History and Report of OMSEP Examination<br><b>SF 88 &amp; 93</b>  |
| Initial/Baseline or Separation             | _____ | Chest x-ray (PA)  |
| <b>Periodic/Separation /Acute Exposure</b> | _____ | <b>CG 5447</b> (update)   |
| All types except acute exposure            | _____ | Vision screening (distant and near)   |
| All types                                  | _____ | Pulmonary function tests (FVC & FEV <sub>1</sub> ).   |
| All types                                  | _____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC).   |
| All types                                  | _____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) |
| All types                                  | _____ | U/A with microscopic  |
| <b>Acute exposure</b>                      | _____ | Blood lead and/or heavy metal screen, <b>if indicated</b> .   |
| All types                                  | _____ | Physician's notification regarding examination results. (Final action.)   |

### To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: **smoking history, weight loss, headache, visual disturbances, difficulty concentrating, decreased attention span, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, shortness of breath, anemia.**
- ◆ Ensure that the patient is examined for the following signs: **gingivitis, sialorrhea, tremor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, respiratory rhonchi and hyperresonance, dermatitis, edema.**
- ◆ Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- ◆ The hazardous waste protocol involves medical surveillance for effects of exposure to a variety of heavy metals and chemical compounds. Neurotoxicity, pulmonary disease, dermatitis, and cancer are possible effects of excessive exposures to hazardous wastes.
- ◆ OMSEP participants monitored under this protocol are primarily members of HAZMAT and spill response teams, firefighters, and marine safety inspectors. Individual, specific exposure histories are often ill defined. If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-5

|  |       |        |             |
|--|-------|--------|-------------|
| Date:  | Unit: | OPFAC: | Unit POC:   |
| Patient name:  |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |        |             |
| Other _____  |       |        |             |

## Examination Protocol for Exposure to Lead

| IF EXAM TYPE IS                           | ✓     | DO or COMPLETE THESE ITEMS   |
|---|-------|--|
| <b>Initial/Baseline</b>                   | _____ | CG-5447 History and Report of OMSEP Examination<br><b>SF 88 &amp; 93</b>   |
| All types                                 | _____ | Blood lead and zinc protoporphyrin (ZPP)   |
| All types                                 | _____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology.                 |
| <b>Periodic/Separation/Acute Exposure</b> | _____ | <b>CG 5447</b> (update)  |
| All types                                 | _____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase, and uric acid) |
| <b>Acute Exposure</b>                     | _____ | <b>Acute Exposure Form</b>   |
| All types                                 | _____ | U/A with microscopic   |
| All types                                 | _____ | Physician's notification regarding examination results. (Final action.)  |

**To the examining medical officer:**

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: **past lead exposure, smoking history, abdominal pain and cramping, joint and extremity pain, difficulty concentrating, irritability, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, anemia, and infertility.**
- ◆ Ensure that the patient is examined for the following signs: **hypertension, papilledema, gum "lead lines", pallor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, extensor motor weakness.**
- ◆ Lead exposure can cause fatigue, anemia, arthralgias and myalgias, peripheral motor neuropathy, neurobehavioral disturbances and encephalopathy, acute abdominal pain, gout and gouty nephropathy, acute and chronic renal failure, spontaneous abortions, and male infertility.
- ◆ If the blood lead level is greater than 40 µg/100 g of whole blood, the employee must be medically removed from any workplace exposure.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-6

|  |       |   |             |
|--|-------|---|-------------|
| Date:  | Unit: | OPFAC:  | Unit POC:   |
| Patient name:  |       | SSN:  | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |   |             |
| Other _____  |       |   |             |
| <b>Examination Protocol for Exposure to</b><br><b>Noise</b>  |       |   |             |
| <b>IF EXAM TYPE IS</b>   |       | <b>✓ DO or COMPLETE THESE ITEMS</b>   |             |
| <b>Initial/Baseline</b>  |       | _____ CG-5447 History and Report of OMSEP Examination<br>_____ SF 88 & 93<br>_____ <b>CG-5552 Audiology History Questionnaire</b><br>_____ <b>DD Form 2215 (optional) or equivalent locally reproduced version.</b> |             |
| Periodic, Separation, or Acute Exposure  |       | _____ DD Form 2216 (optional) or equivalent locally reproduced version.   |             |
| All types  |       | _____ Physician's notification regarding examination results. (Final action.)   |             |

**To the examining medical officer:**

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Review and initial the CG-5552 Audiology History Questionnaire and the audiogram results.
- ◆ A significant threshold shift (STS) exists if the **average** change in hearing from the reference audiogram at, 2000, 3000, and 4000 Hz is greater than or equal to  $\pm 10$  dB in either ear.
- ◆ Additionally, any change of  $\pm 15$  dB at 1000, 2000, 3000, or 4000 Hz in either ear constitutes an STS.
- ◆ Do not apply the National Institute for Occupational Safety and Health (NIOSH) age corrections when determining STS.
- ◆ Follow-up audiograms must be conducted when an individual's audiogram shows an STS relative to the current reference audiogram in either ear. When a positive STS (decrease in hearing threshold) is noted, two 14-hour noise-free follow-up tests must be administered to confirm that the decrease in hearing is permanent. When a negative STS (improvement in hearing) is noted, one 14-hour noise-free follow-up tests must be administered.
- ◆ Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. That evaluation must be performed by an audiologist, and otolaryngologist, or other knowledgeable physician.
- ◆ If, compared with the **current** reference audiogram, a loss of hearing of  $\geq 35$  dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz) is noted, the employee must be medically removed from further workplace exposure.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-7

|  |       |        |             |
|--|-------|--------|-------------|
| Date:  | Unit: | OPFAC: | Unit POC:   |
| Patient name:  |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |        |             |
| Other _____  |       |        |             |

## Examination Protocol for Exposure to Pesticides

| IF EXAM TYPE IS                               | ✓     | DO or COMPLETE THESE ITEMS  |
|---|-------|---|
| <b>Initial/baseline</b>                       | _____ | CG-5447 History and Report of OMSEP Examination   |
|   | _____ | <b>SF 88 &amp; 93</b>   |
|   | _____ | Blood cholinesterase level, two specimens at least 24 hrs. apart  |
| <b>Periodic/ Separation or Acute Exposure</b> | _____ | Blood cholinesterase level, <b>if current exposure involves organophosphate or carbamate pesticides</b>                       |
|   | _____ | CG 5447 (update)  |
| All types                                     | _____ | Pulmonary function tests (FVC & FEV <sub>1</sub> ).   |
| All types except acute exposure               | _____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC)  |
| All types except acute exposure               | _____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) |
| All types except acute exposure               | _____ | U/A with microscopic  |
| <b>Acute Exposure</b>                         | _____ | <b>Acute Exposure Form</b>  |
| All types                                     | _____ | Physician's notification regarding examination results. (Final action.)   |

### To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: **past and current exposures to pesticides, smoking and alcohol use history; eye, nose or throat irritation; cough; nausea, vomiting, diarrhea or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; allergic skin conditions or dermatitis.**
- ◆ Ensure the patient is examined for the following possible signs: **dermatitis, meiosis, rhinitis, mental status changes.** Pulmonary system must be examined if respiratory protection is used.
- ◆ If the cholinesterase level is at or below 50% of the pre-exposure baseline, the employee must be medically removed from any further workplace exposure.
- ◆ Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase. They cause parasympathetic nervous system hyperactivity, neuromuscular paralysis, CNS dysfunction, peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-8

|  |       |   |             |
|--|-------|---|-------------|
| Date:  | Unit: | OPFAC:  | Unit POC:   |
| Patient name:  |       | SSN:  | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Other |       |   |             |
| <p>Examination Protocol for Exposure to</p> <h2>Respirator Wear</h2>   |       |   |             |
| IF EXAM TYPE IS  | ✓     | DO or COMPLETE THESE ITEMS  |             |
| Initial/Baseline   | _____ | OSHA Respiratory Medical Evaluation Questionnaire                       |             |
| Periodic/Exit/Separation   | _____ | OSHA Respiratory Medical Evaluation Questionnaire (update).             |             |
| All types  | _____ | Physician's notification regarding examination results. (Final action.) |             |

**To the examining medical officer:**

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ This protocol applies to all employees required to wear a respirator in the course of their work.
- ◆ Ensure that the patient is questioned about the following history or symptoms: **past and current exposures to hazardous chemicals, fumes, and dusts; smoking and alcohol use history; any history of claustrophobia, asthma, angina, syncope, and other respiratory or cardiovascular disease.**
- ◆ Ensure the patient is examined for the following possible signs: **wheezing or other abnormal breath sounds, clubbing, and cardiac arrhythmias.**
- ◆ You must address whether the employee has any detected medical conditions which would place him or her at increased risk of material health impairment from the required respirator use. Consider whether the employee's health will allow him or her to tolerate respirator wear.
  - \* Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree (FEV1 or FVC <70% of predicted) should not be **routinely** approved to wear a respirator. Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-9

|  |       |        |             |
|--|-------|--------|-------------|
| Date:  | Unit: | OPFAC: | Unit POC:   |
| Patient name:  |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |        |             |
| Other _____  |       |        |             |

Examination Protocol for Exposure to

## Respiratory Sensitizers

| IF EXAM TYPE IS                     | ✓     | DO or COMPLETE THESE ITEMS  |
|-------------------------------------|-------|---|
| <b>Initial/Baseline</b>             | _____ | CG-5447 History and Report of OMSEP Examination   |
|                                     | _____ | <b>SF 88 &amp; 93</b>   |
| <b>Periodic/Exit/Acute Exposure</b> | _____ | <b>CG 5447</b> (update)   |
| All types                           | _____ | Pulmonary function tests (FVC & FEV <sub>1</sub> ).   |
| All types except acute exposure     | _____ | CBC (complete blood count)  |
| All types except acute exposure     | _____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) |
| All types except acute exposure     | _____ | U/A (dipstick sufficient)   |
| <b>Acute Exposure</b>               | _____ | <b>Acute Exposure Form</b>  |
| All types                           | _____ | Physician's notification regarding examination results. (Final action.)   |

**To the examining medical officer:**

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: **past and current exposures to respiratory sensitizers, smoking history; eye, nose or throat irritation; cough; asthma or other chronic airway problems; allergic skin conditions or dermatitis.**
- ◆ In the event that the employee is not required to wear a respirator, and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a directed physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used.
- ◆ Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).
- ◆ In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-10

|  |       |        |             |
|--|-------|--------|-------------|
| Date:  | Unit: | OPFAC: | Unit POC:   |
| Patient name:  |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |        |             |
| Other _____  |       |        |             |

## Examination Protocol for Exposure to Solvents

| IF EXAM TYPE IS                     | ✓     | DO or COMPLETE THESE ITEMS  |
|-------------------------------------|-------|---|
| <b>Initial/Baseline</b>             | _____ | CG-5447 History and Report of OMSEP Examination   |
|                                     | _____ | <b>SF 88 &amp; 93</b>   |
| All types                           | _____ | Pulmonary function tests (FVC & FEV <sub>1</sub> ).   |
| All types except acute exposure     | _____ | CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC)  |
| <b>Periodic/Exit/Acute Exposure</b> | _____ | <b>CG 5447</b> (update)   |
| All types except acute exposure     | _____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) |
| All types except acute exposure     | _____ | U/A with microscopic  |
| <b>Acute exposure</b>               | _____ | <b>Acute Exposure Form</b>  |
| All types                           | _____ | Physician's notification regarding examination results. (Final action.)   |

### To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: **past and current exposures to solvents, smoking and alcohol use history; allergic skin conditions, dry skin, or dermatitis ; eye, nose or throat irritation; headache, nausea, vomiting, dizziness, vertigo; fatigue, weakness, irritability, depression, difficulty concentrating, or impaired short-term memory; and numbness, tingling, or weakness in the extremities.**
- ◆ Ensure the patient is examined for the following possible signs: **dermatitis, peripheral neuropathy, cognitive dysfunction, and mental status changes.**
- ◆ If the particular solvent exposure is well characterized and specific laboratory tests are available, biological monitoring should be considered.
- ◆ Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- ◆ There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when taken as a broad group. These effects are skin disorders, and acute and chronic CNS effects. Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic in humans; benzene being a notable exception.
- ◆ In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-11

|  |       |        |             |
|--|-------|--------|-------------|
| Date:  | Unit: | OPFAC: | Unit POC:   |
| Patient name:  |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |        |             |
| Other _____  |       |        |             |

Examination Protocol for Exposure to

## Tuberculosis

| IF EXAM TYPE IS  | ✓     | DO or COMPLETE THESE ITEMS  |
|--|-------|---|
| <b>Initial/Baseline</b>                                  | _____ | CG-5447 History and report of OMSEP Examination<br><b>SF 88 &amp; 93</b>  |
| All types, <b>no</b> history of prior reactive skin test | _____ | Mantoux tuberculin skin test (TST)<br>Enter results on SF 601 and PHS 731 |
| All types, <b>history of prior reactive skin test</b>    | _____ | SF 600 entry  |
| Follow-up on newly reactive TST                          | _____ | CG-5447 (update)<br><b>CXR (only if TST is newly reactive)</b>            |
| All types  | _____ | Physician's notification regarding examination results. (Final action.)   |

**To the examining medical officer:**

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ **For personnel with a prior history of a reactive TST**, ensure the patient is questioned about the following symptoms of active TB: **fever, night sweats, weight loss, cough, and hemoptysis**. This questioning may be completed by a nurse or health services technician.
- ◆ See section 7-D of the Medical Manual for full information on the tuberculosis control program.
- ◆ Forward a copy of all test results to the unit OMSEP coordinator.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.



FIGURE 12-C-12

|  |       |        |             |
|--|-------|--------|-------------|
| Date:  | Unit: | OPFAC: | Unit POC:   |
| Patient name:  |       | SSN:   | Unit Phone: |
| Exam type: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Exit/Separation <input type="checkbox"/> Acute exposure <input type="checkbox"/> |       |        |             |
| Other _____  |       |        |             |

## Examination Protocol for Exposure to **Unspecified**

| IF EXAM TYPE IS                     | ✓     | DO or COMPLETE THESE ITEMS  |
|-------------------------------------|-------|---|
| <b>Initial/Baseline</b>             | _____ | CG-5447 History and Report of OMSEP Examination<br><b>SF-88 &amp; 93</b>  |
| All types                           | _____ | CBC (complete blood count)  |
| All types                           | _____ | Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) |
| <b>Periodic/Exit/Acute Exposure</b> | _____ | <b>CG 5447</b> (update)   |
| All types                           | _____ | U/A (dipstick)  |
| <b>Acute exposure</b>               | _____ | <b>Acute Exposure Form</b>  |
| All types                           | _____ | Physician's notification regarding examination results. (Final action.)   |

### To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about his or her general medical and work history, including: **past and current exposure to chemical and physical hazards, smoking history and alcohol use, and a complete review of systems.**
- ◆ Ensure the patient receives a complete physical examination of all systems, **with attention to any organ systems with a significant history or current systems.**
- ◆ Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- ◆ Individuals under going surveillance in this protocol have exposures to hazards which are not included in any of the other protocols.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.